

PEPFAR Zimbabwe

Country Operational Plan (COP) 2016

Strategic Direction Summary

Revised May 25, 2016

Table of Contents

Goal Statement

1.0 Epidemic, Response, and Program Context

- 1.1 Summary statistics, disease burden and epidemic profile
- 1.2 Investment profile
- 1.3 Sustainability Profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

2.0 Core, near-core and non-core activities for operating cycle

3.0 Geographic and population prioritization

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

- 4.1 Targets for scale-up locations and populations
- 4.2 Priority population prevention
- 4.3 Voluntary medical male circumcision (VMMC)
- 4.4 Preventing mother-to-child transmission (PMTCT)
- 4.5 HIV testing and counseling (HTC)
- 4.6 Facility and community-based care and support
- 4.7 TB/HIV
- 4.8 Adult treatment
- 4.9 Pediatric Treatment
- 4.10 OVC

5.0 Program Activities to Maintain Support in Other Locations and Populations

- 5.1 Maintenance package of services and expected volume in other locations and populations
- 5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

- 6.1 Laboratory strengthening
- 6.2 Strategic information (SI)
- 6.3 Health system strengthening (HSS) – clear linkages to program

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Appendix A- Core, Near-core, Non-core Matrix

Appendix B- Budget Profile and Resource Projections

Appendix C- Sustainability Index and Dashboard

Acronym List

ACT	Accelerating Children's Treatment
AGYW	Adolescent girls and young women
ART	Antiretroviral Treatment
ARVs	Antiretroviral Drugs
CARGS	Community Adherence Refill Groups
CATS	Community Adolescents Treatment Support Groups
CCM	Global Fund Country Coordinating Mechanism
CeSSHAR	Center for Sexual Health and HIV/AIDS Research
CHAI	Clinton HIV/AIDS Initiative
CIFF	Children Investment Fund Foundation
DfID	Department for International Development
DHIS ₂	District Health Information Software 2
DREAMS	Determined Resilient Empowered AIDS-Free Mentored and Safe
DSD	Direct Service Delivery
EID	Early Infant Diagnosis
ePMS	Electronic patient monitoring system
FP	Family Planning
FSW	Female Sex Worker
GALZ	Gay and Lesbian Association of Zimbabwe
GBV	Gender-Based Violence
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOZ	Government of Zimbabwe
HRH	Human Resources for Health
HTS	HIV Testing and Counseling Services
IPC	Interpersonal Communication
MOHCC	Ministry of Health and Child Care
MSM	Men who have sex with Men
NAC	National AIDS Council
NASA	National AIDS Spending Assessment
OVC	Orphans and Vulnerable Children
PITC	Provider Initiated Testing and Counseling
PITC+	Provider Initiated Testing and Counseling including HRH
PLHIV	People Living with HIV
POART	PEPFAR Oversight and Accountability Response Team
PreP	Pre-Exposure Prophylaxis
RDS	Respondent Driven Surveys
RTK	Rapid Test Kits
SID	Sustainability Index Dashboard
SIMS	Site Improvement for Monitoring Systems

SNU	Sub-National Unit
STI	Sexually Transmitted Infection
TA	Technical Assistance for Service Delivery Improvement
TBIC	TB infection control
UNAIDS	Joint United Nations Programme on HIV/AIDS
VHWs	Village Healthcare Workers
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZDHS	Zimbabwe Demographic Health Survey
ZIMPHIA	Zimbabwe Population based HIV Impact Assessment

Goal Statement

Building on the geographic prioritization developed in COP 2015, the PEPFAR program will continue to invest in the delivery of a comprehensive package of HIV care, treatment, and prevention activities within 36 of Zimbabwe's 60 districts. Utilizing the 2014 estimates for the number of people living with HIV (PLHIV), the PEPFAR program will refine activities to target populations within districts where the gap to saturation is higher. The PEPFAR program will support the Ministry of Health and Child Care (MOHCC) to reach treatment saturation by the end of FY 2017 in 17 districts, and 19 districts by the end of FY 2018. This will be achieved through a direct service delivery model focused in Harare/Chitungwiza, *Determined Resilient Empowered AIDS-Free Mentored and Safe* (DREAMS) and Aggressive Saturation districts to identify PLHIV through provider initiated testing and counseling (PITC), targeted outreach, defaulter tracing and adherence counseling, surge Human Resources for Health (HRH) capacity, and community index testing. In a change from COP 2015, the PEPFAR program will no longer support 54 high-volume sites located in the sustained districts and will redirect this support to a central package including procurement and distribution of antiretroviral (ARVs) drugs and viral load (VL) reagents.

The PEPFAR program will increase the number of people for whom it provides ARVs to 192,989 patients. The program will also continue to support voluntary medical male circumcision (VMMC), orphan and vulnerable children (OVC), and targeted high-impact prevention activities. To accommodate some of these changes and to align with the overall goal of achieving 90-90-90, the PEPFAR program has made several reductions. Funding for the District Health Information Software 2 (DHIS2), decentralization of electronic patient monitoring system (ePMS) and tuberculosis infection control has been reduced; while funding for a drug resistance surveillance, implementation science, and integrated HIV trainings has been eliminated. Funding for the condom program has been used to develop a Key Populations strategy to scale-up clinical services targeting female sex workers (FSW) and men who have sex with men (MSM). Funds 'saved' from the aforementioned activities will be used to support direct service delivery activities including: human resources, community ART refill groups (CARGS), mobile outreach initiation units and viral load reagents to catalyze the national VL scale-up plan which is currently at 6% of ART patients nationwide.

The PEPFAR team has actively collaborated with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), bilateral and multilateral health development partners, and civil society to ensure program changes align with national objectives. The national ART program and other critical HIV programs in Zimbabwe are implemented with the leadership and largely with the manpower and infrastructure of the Ministry of Health and Child Care (MOHCC). PEPFAR has successfully leveraged this capacity with key commodities, training, mentoring, and site-level support to scale up national coverage. Based on the estimated number of PLHIV in each district, the 36 scale-up districts with the greatest number of PLHIV were chosen in order to reach 80% of the total population in need of services. In order to focus further within those districts, the program will continue to concentrate on higher-volume sites and will only deliver services at sites with over 260 ART patients. The program will coordinate with the GoZ and GF to ensure that sites in non-scale-up districts and in smaller sites (<260 ART patients) within scale-up districts continue to receive ARVs and other key commodities.

PEPFAR Zimbabwe is committed to attaining the 90-90-90 goals outlined by UNAIDS, with plans to work with the MOHCC to begin implementation of Treat All (Test and Start). The National guideline adaptation process is underway with full national roll-out expected before the end of calendar year 2016. Three provinces (inclusive of four DREAMS Districts) have received the greenlight to commence Treat All as of July 2016.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

According to the 2012 census, the total population of Zimbabwe was 13.1 million. As of July 2015, the figure is estimated to have grown to 14.2 million based on preliminary demographic survey data. Current national HIV data shows that an estimated 1.55 million people were living with HIV in 2014 with an estimated prevalence among people aged 15-49 years of 16.7%. Annual AIDS related deaths have declined over the past decade with approximately 38,616¹ AIDS related deaths in 2014 compared to 134,247 in 2004. Zimbabwe has seen a decline in HIV incidence rates among adults aged 15-49 years from 2.63% in 2000 to 0.92% in 2014 due to the scale up of various prevention and treatment programs. In terms of absolute numbers, the new HIV infections among all adults 15+ years declined nationally from 110,989 in 2000 to 54,762 in 2014. Among children the decline was from 35,893 in 2000 to 9,086 in 2014. By the end of 2014, ART coverage among all HIV+ adults was 51% and 39% among children.

Looking forward, the Zimbabwe Ministry of Health and Child Care estimates 2015 HIV Prevalence at 16.14% among adults ages 15-49 and annual AIDS Deaths at 23,651. Similarly, the annual incidence among adults will be 0.65%, down from 5.92% in 1995 and 1.37% in 2009. As of December 2015, average ART initiation is about 8,689 persons per month, however, a major risk in achieving high ART coverage and epidemic control is insufficient funding for ARVs, human resource shortages, a deteriorating health system and heavy reliance on donor funding. PEPFAR Zimbabwe is joined in its work to reach epidemic control by the Global Fund and the people of Zimbabwe, who contribute to the National AIDS Trust Fund (“AIDS Levy”) through a 3% income tax, which totaled \$34.2 million in 2013². Combined funding from PEPFAR and the Global Fund per PLHIV is lowest for Zimbabwe among ten sub-Saharan African countries classified as low income by the World Bank. The GNI per capita last measured in 2014 was \$840. The government of Zimbabwe contributes about 20% of the funds for their annual HIV response, and approximately 36% of the national budget is dedicated to the overall health sector³, though past years’ actual disbursements have amounted to just 10% of the program implementation⁴.

PEPFAR Zimbabwe is committed to attaining the 90-90-90 goals outlined by UNAIDS, with plans to work with the MOHCC to begin implementation of Treat All in 6 priority districts beginning in July 2016 and a national rollout beginning in October 2016.

¹ Zimbabwe 2014 HIV/AIDS Estimates

² Total 2015 AIDS Levy revenue is unknown, however the proportion of NAC funds allocated to commodities is estimated at \$16 million per year for both 2016 and 2017.

³ MOHCC Resource Mapping 2015

⁴ Confirmed verbally by MOHCC officials on several occasions

Table 1.1.1 Key National Demographic and Epidemiological Data

Note: Unless otherwise noted, national 2014 data is used as provided in the “Zimbabwe National and Sub-national HIV/AIDS Estimates 2014” published by the Ministry of Health and Child Care – June 2015.

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Pop	13,061,239		2,691,143	50.1%	2,681,128	49.90%	4,089,557	53.2%	3,599,411	46.8%	ZIM 2012
Prevalence (%)							16.7% (ages 15-49)				Nat'l estimates 2014.
AIDS Deaths per year	38,616		7,916		7,916		12,075		10,709		National HIV and AIDS estimates 2014.
PLHIV	1,550,250		146,824				830,866	59%	572,560	41%	National HIV and AIDS estimates 2014.
Incidence Rate (Yr.)	0.88%						0.92% (ages 15-49)				National HIV and AIDS estimates 2013.
New Infections (Yr.)	54,762										National HIV and AIDS estimates 2014
Annual births	416,988										Population census 2012; (416988/3 271 393 (number of child bearing age women))
% >= 1 ANC visit		93.3%	Data not available	Data not available			Data not available	not available			DHS 2010/2011
Pregnant women needing ARVs	75,009	100%									National HIV and AIDS estimates 2013; (mothers needing PMTCT 31 Dec)
Orphans (maternal, paternal, double)	889,339		889,339 aged 0-14 yrs.		889,339 aged 0-14 yrs.		Data not available		Data not available		National HIV and AIDS estimates 2013

TB cases (Yr.)	28,508 (total case notification)		1,300		1,370		14,251		18,645		NTP Data for 2013 WHO Global TB report
TB/HIV Co-infection	22,442	69%	Data not available	Global TB report 2014, WHO							
Males Circumcised ^[1]	364,320 (all ages)				143,812				220,508		MOH VMMC program data 2009 -Sep 2014)
MSM HIV Prevalence		23.5% (Sexual Minorities and HIV in Zimbabwe Draft Report (2013 BRTI))									2013 research carried out by Biomedical Research Training Institute in collaboration with GALZ and NAC.
Total FSW	~40,000-80,000 (Approximation, based on RDS 2011-2013)										RDS 2011-2013)
FSW HIV Prevalence		57.5% (SAPPH-IRE Baseline, 2013)									(SAPPH-IRE Baseline, 2013)
Total PWID	Data not available	Data not available									
PWID HIV Prevalence	Data not available	Data not available									
Priority Populations Men 15-29	1,776,239	13.6% (of total population)							1,776,239	Data not available	
Priority Populations Women 15-24	1,371,430	10.5% (of total population)							1,371,430		

Priority Populations Women 24-29	613,878	4.7% (of total population)							613,878		
Priority Populations Men 30-49	1,240,817	9.5% (of total population)									
Priority Populations Men 30-49	1,306,124	10% (of total population)									
Priority Populations	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	See HIV prevalence table below

**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*

[1 MC coverage for 15-29 year olds is 185,337 of total population of 15-29 year olds 1,286,918 – 14%.](#)

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	13,061,239	16.7 (15-45y)	1,550,250	777,267	85%. (HIV drug resistance EWI report 2013)	89.6% (HIV drug resistance monitoring survey report 2009-2011)	1,277,772 Year 2015 – HTC Program data)	99,788 Year 2015 – HTC Program data)	Data not available
Population less than 15 years	5,390,210 (est)	2.7	146,824	55,061	Data not available	Data not available	122,313 Year 2015 – HTC Program data)	5,050 Year 2015 – HTC Program data)	Data not available
Pregnant Women	412,120 (For Yr. 2013) National HIV and AIDS estimates 2013	15.9% (15-49 years) ANC 2013 report	75,009 (est. mothers need PMTCT)	59,190 (number receiving PMTCT)	NA	NA	NA	NA	NA
MSM	Pending Size Estimation	23.5%(Sexual Minorities and HIV in Zimbabwe Draft Report (2013 BRTI)	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
FSW	~40,000-	57.5%	24,667	~30%	Data not	Data not	Data not	Data not available	~30%

	80,000 (Approximation, based on RDS 2011-2013)	(SAPPHIRE Baseline, 2013)	(MOT estimate 2009)	Cowan F PLoS ONE 2013	available	available	available	(~50%, Cowan F PLoS ONE 2013)	Cowan F PLoS ONE 2013
PWID	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	

1.2 Investment Profile

The HIV response in Zimbabwe is funded primarily from five sources– PEPFAR, the Global Fund, other bilateral donors (DfID, EU, Switzerland and Sweden), the private sector and the national government (GoZ/NAC, National AIDS Spending Assessment 2012). Annual PEPFAR support grew by approximately 74% between 2011 and 2012 and is now maintaining level funding (\$95 million COP support; \$7-15 million central initiative funding). As a recipient of DREAMS initiative funding, the country will also receive an additional \$41 million for prevention activities targeting adolescent girls and young women.

Zimbabwe was one of three countries chosen to participate in the GF New Funding Model (NFM) pilot; receiving \$145 million per year (\$437 million grant). The current grant started in January 2014 and will end in December 2016. The country received an additional \$25 million through Incentive Funding and \$6 million for pediatric treatment from the Children Investment Fund Foundation (CIFF).

Government health spending has slowly declined with currently expenditures at 7.6% of the total GoZ budget. Funding for MOHCC continues at \$330 million per year in the 2014 and 2015 budget. While these funds are primarily allocated for MOHCC personnel costs, a critical component of the national HIV response, the actual funding disbursement is only approximately 10% of the budgeted amount. On a positive note, at the end of November 2014, the Minister of Finance announced that the AIDS Levy (NATF) would be extended to the mining sector in 2015 which is expected to add approximately \$13 million to the annual revenue of the Fund, 35% of which is expended on ARVs.

Table 1.2.1 Investment Profile by Program Area^{5 6}

Program Area	Total Expenditure	% Pvt sector				
		% PEPFAR	% GF	% GOZ/NAC	% HDPG	
Clinical care, treatment and support	158,565,455	32.54	24.95	15.64	22.38	
Community-based care	524,316	-	50.16	-	49.84	
PMTCT	6,094,830	64.50	6.97	-	28.53	
HTC	7,283,825	42.83	47.29	-	9.87	
VMMC	53,414,361	59.40	13.25	-	27.35	
Priority population prevention*	52,160,392	47.69	9.8	4.35	2.11	
Key population prevention*	1,416,490	-	29.37	60.72	9.92	
OVC*	14,676,306	49.34	-	0.84	27.26	
Laboratory	504,000	100.00	-	-	-	
SI, Surveys and Surveillance	7,726,594	19.93	77.74	0.13	-	
HSS	42,767,954	4.90	60.58	19.75	11.43	
Total	297,334,523	29.88%	26.13%	11.63%	18.77%	

⁵ GRP, National AIDS Spending Assessment, 2012), all amounts in 2012 USD

⁶ Note that Priority Population Prevention, Key Pop and OVC are not individual lines in the NASA

Table 1.2.2 Procurement Profile for Key Commodities⁷

Commodity Category	Total Expenditure	% PEPFAR	% Global Fund	% GOZ/NAC	% Other	% Gap
ARVs	\$146,272,663.90	19.40	59.10	8.20	0	13.30
Rapid test kits	\$5,309,761.62	0	81.20	18.80	0	0
Other drugs	\$1,152,502.46	12.00	60.40	0	0	27.60
Lab reagents (EID)	\$1,001,347.20	0	100	0	0	0
Lab reagents (POC)	\$2,517,316.48	0	100	0	0	0
Lab reagents (conventional)	\$12,454,763.20	0	59.00	0	0	41.00
Lab reagents (VL)	\$19,570,642.00	15.30	26.50	0	0	58.20
Condoms (male & female)*	\$6,494,482.00	100	0	0	0	0
VMMC kits	\$8,667,596.01	45.70	26.00	0	0	28.30
Other commodities	\$2,446,631.96	42.46	50.78	0	0	6.76
Total	\$205,887,706.83					

National Sustainability Profile

SID Process: On February 19 and 24 the PEPFAR team met with the MOHCC and National AIDS Council (NAC) to pre-populate the Sustainability Index Dashboard (SID) tool. On February 22, PEPFAR representatives also met with the Clinton Health AIDS Initiative (CHAI) who has taken a leadership role in sustainable financing. On February 26 UNAIDS and PEPFAR co-convened a stakeholder validation meeting with participants from the MOHCC, NAC, Global Fund Country Coordinating Mechanism (CCM) members, implementing partners, civil society, and other development partners. After an introductory address and clarification regarding the purpose of the SID from UNAIDS and the PEPFAR team, the participants divided into four domain subgroups to discuss and validate the SID questionnaire based on the data and information assembled. The subgroups had a facilitator from PEPFAR, UNAIDS, and CHAI to validate agreed upon scores, record data sources, and document points of clarification and context. Upon completion of subgroup discussion, the full group then reconvened at the end of the day to review the completed tool, discuss the findings and validate the conclusions.

⁷ **Note:** All commodity groups are based on the CY 2017 forecast and commitments from preliminary results presented after the February/March 2016 quantification exercise.

*Male and female condoms are for the public sector program. Refer to PSI for social marketing

- 1) For all commodity categories supported by Global Fund, it was assumed that Global Fund CY2017 funding will be the same as CY2016 funding levels, except for ARVs where it was assumed that the only Global Fund supported patients on ART at December 31, 2016 will be supported in 2017. These assumptions are pending the 2017 bridge year funding proposal and Global Fund Secretariat approval.
- 2) Rapid test kits do not include the tests required for syphilis.
- 3) Other drugs refers to drugs used in the VMMC program.
- 4) VMMC kits include requirements for surgical and PrePex methods.
- 5) Other commodities refers to commodities and equipment used in the VMMC program other than the VMMC kits.

Sustainability Strengths:

- **Planning and Coordination (9.33, dark green)**: The MOHCC effectively leads the coordination of the HIV response in Zimbabwe. A multi-year, costed national strategy exists, including specific activities and strategies to minimize the impact of HIV on vulnerable populations. The MOHCC also continues to effectively lead the implementation of the National HIV Implementation, and coordination with NAC is strong. The MOHCC has made great effort to ensure the development of the national strategy is an inclusive process.
- **Quality Management (8.67, dark green)**: The GoZ has institutionalized quality management systems and plans to ensure quality improvement methodologies are applied to managing and providing HIV/AIDS services. For example, peer-learning opportunities are being developed and will be available by the end of 2016. Additionally, HIV program performance measurement data are used to identify areas of patient care and service that can be improved through national decision-making, policy, and priority setting.

Sustainability Vulnerabilities:

- **Private Sector Engagement (2.71, red)**: Private sector engagement needs increased attention. For example, the private sector does not actively engage with the GoZ as part of the policy and budget decision for HIV programs. Additionally, the policy legal and regulatory frameworks make limited provisions for the needs of private businesses.
- **Domestic Resource Mobilization (3.06, red)**: The GOZ continues to remain highly dependent on outside donors to fund their national HIV response. Current resource mapping shows around 20% of total funding is from the GOZ.
- **Epidemiological and Health Data (3.87, yellow)**: Zimbabwe requires additional capacity to lead and manage planning and implementation of epidemiological survey and surveillance activities. Additionally, key population epidemiological and behavioral surveillance activities are not funded or conducted by the MOHCC, but by external agencies, organization, and institutions. Lastly, there is a lack of reporting for viral load data and viral load testing is not done routinely at clinics.
- **Laboratory (4.72, yellow)**: Like many other components of service delivery, there are strategies in place, but not fully operationalized at all levels of the system. The entire network of laboratories and monitor quality is not covered. There remain large gaps in capacity of laboratory workforce, viral load infrastructure, and domestic funds for laboratories as a whole.
- **Commodity Security and Supply Chain (6.14, yellow)**: ARV funding for future years is uncertain given that planning for the Global Fund beyond 2016 is currently unknown. Furthermore, as ART coverage is expected to increase with the introduction of Treat All, ARV needs will increase while overall funding is expected to remain stable or decrease. Supply chain systems are relatively strong, but still heavily reliant on support from outside donors.

Additional Observations: Commodity shortages, especially for ARVs and viral load instrument and reagents, remain an area of concern that requires immediate attention.

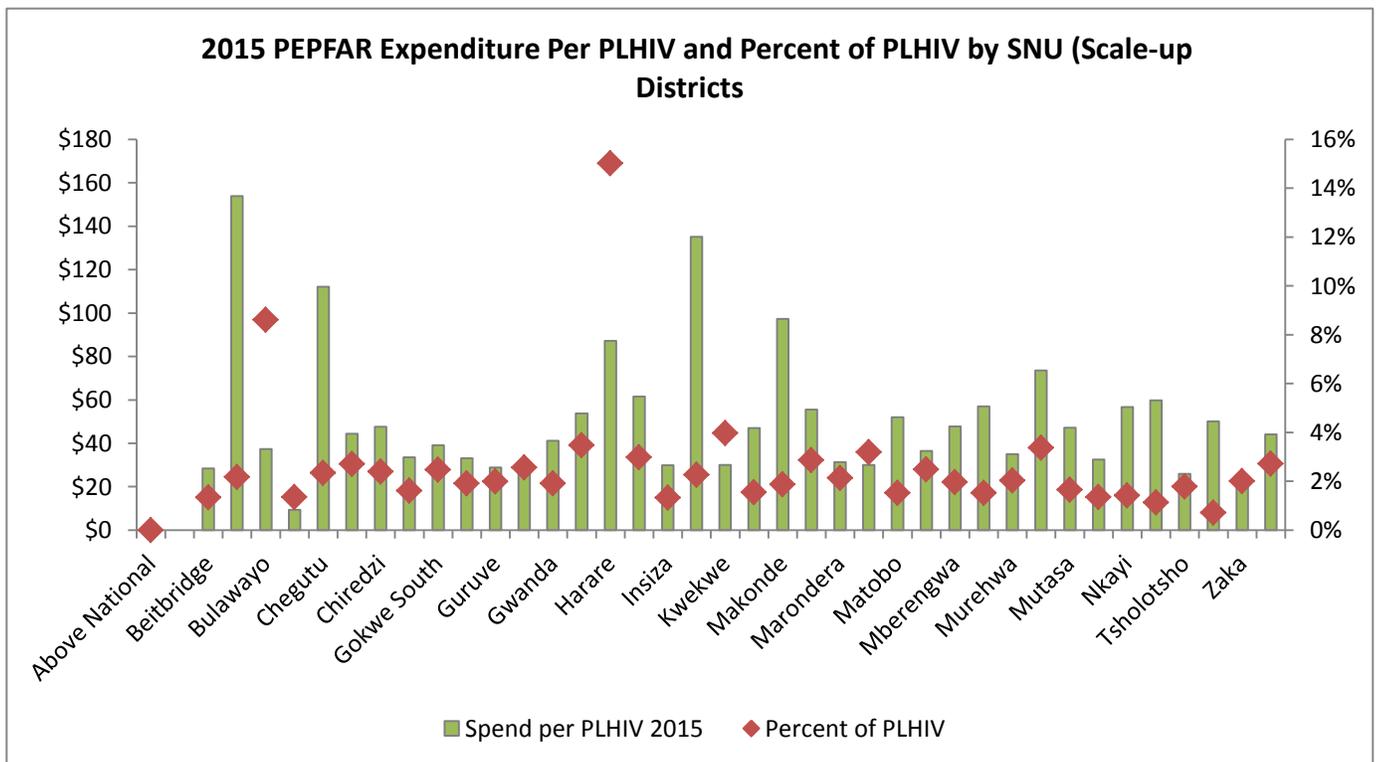
Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT	\$0	\$0			Accelerating Pediatric Treatment
DREAMS	\$23,648,362	\$23,648,362	6	\$7,192,356 (OVC Mech)	HIV Prevention for AGYW
DREAMS Innovation	TBC	TBC			66 Applications Received Requesting \$159M
DREAMS Test & Start-Men	\$9,980,772	\$9,980,772			Test & Start Strategies to reach Men in six DREAMS Districts
VMMC	\$8,184,744	\$8,184,744			VMMC Scale-up in Six DREAMS Districts to reach saturation
Central HOP for Condoms	\$7,473,935	\$0			Central Funding will procure 6,324,000 female and 104,037,000 male condoms
Local Capacity Initiative	\$1,900,000	\$1,900,000			Final Year for Local Partner capacity building
Together for Girls	\$1,400,000	\$1,400,000	2		Final Year; Pending Activity for the Families Matter Evaluation
USAID MCH	\$3,000,000				Reduce MNCH morbidity and mortality and improve quality of care for MNCH services.
USAID TB	\$6,000,000				Improve TB control through diagnostics, treatment, and infection control.
USAID Family Planning	\$2,000,000	\$2,000,000			Increase access to and availability of FP services through private franchise model
USAID Supply Chain		\$3,600,000	1		Forecasting procurement and distribution of medicines and commodities
USAID Malaria	\$15,000,000				Improve malaria control through case management, long-lasting insecticidal net distribution, and indoor residual spraying.
Total	\$78,587,813	\$50,713,878	9	\$7,192,356	

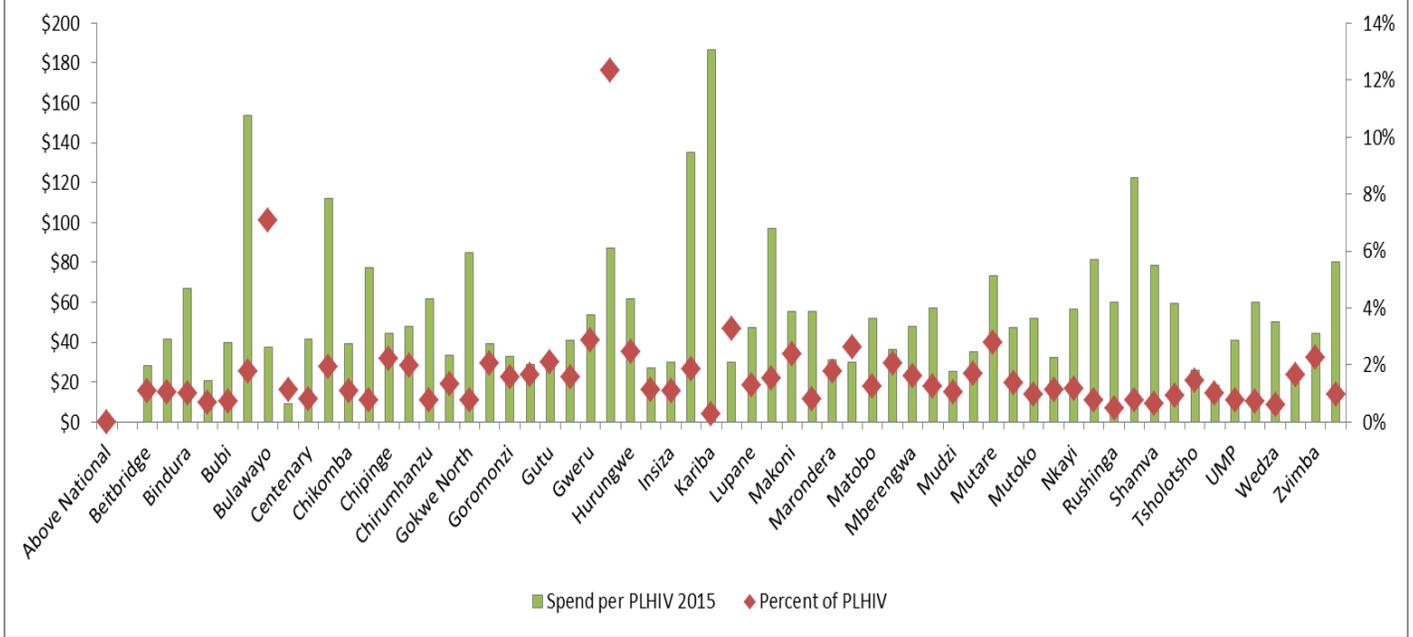
Alignment of PEPFAR investments geographically to disease burden

Figure 1.4.2 compares PEPFAR USD/PLHIV expenditures in 2015 to HIV burden in PEPFAR scale-up SNU and Figure 1.4.3 reflects expenditures in all SNUs. PEPFAR spent on average \$78 per PLHIV in Zimbabwe in 2015 which varied from \$9 in Bulilima (scale-up SNU) to \$186 in Kariba (hotspot SNU). Some of this variation can be explained by different service delivery models, such as outreach activities that operate out of a central district (such as Bulawayo and Harare), a mixture of both direct service delivery and site level technical assistance. Other aberrations in this graphic are due to the fact that PEPFAR support pivoted from a national focus (60 SNUs) to 36 SNUs including hotspots in 4 SNUs. In COP 2016, PEPFAR funding for sustained districts will shift to a central support model and outreach activities in hotspot districts (e.g. Bindura, Kariba, Hwange, and Zvishavane) will be discontinued. Mobility and ARV availability in provincial capitals and select districts further skews the district level HIV burden data. The biggest expenditure differences are related to costs in reaching facilities due to distances from capital centers and remoteness/inaccessibility.

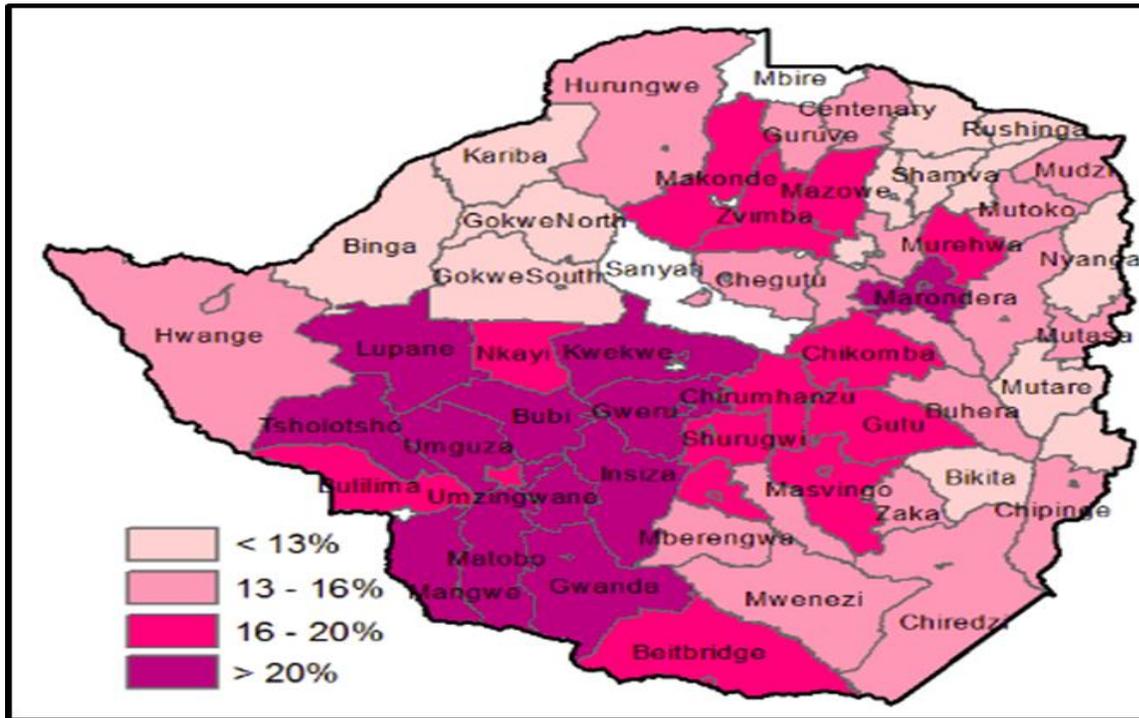
Figure 1.4.2 Total expenditure, PLHIV, and Expenditure per PLHIV by PEPFAR Scale-up District



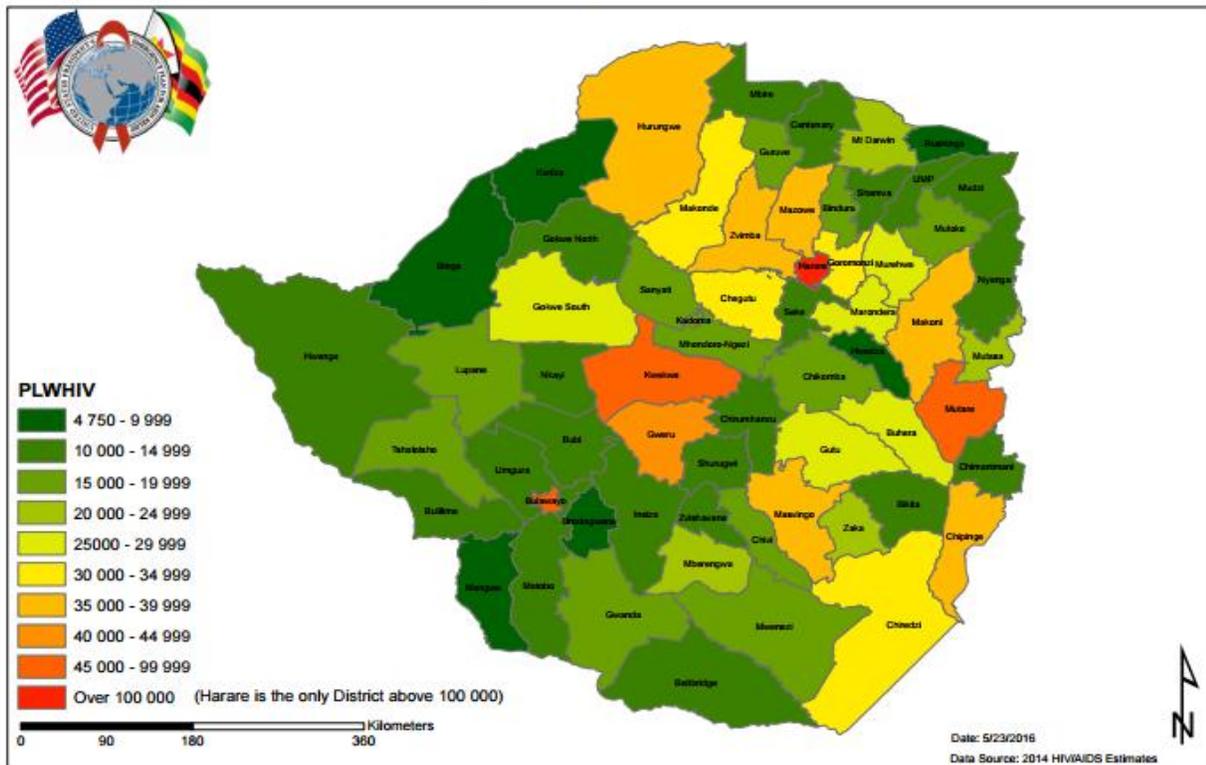
2. 2015 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU



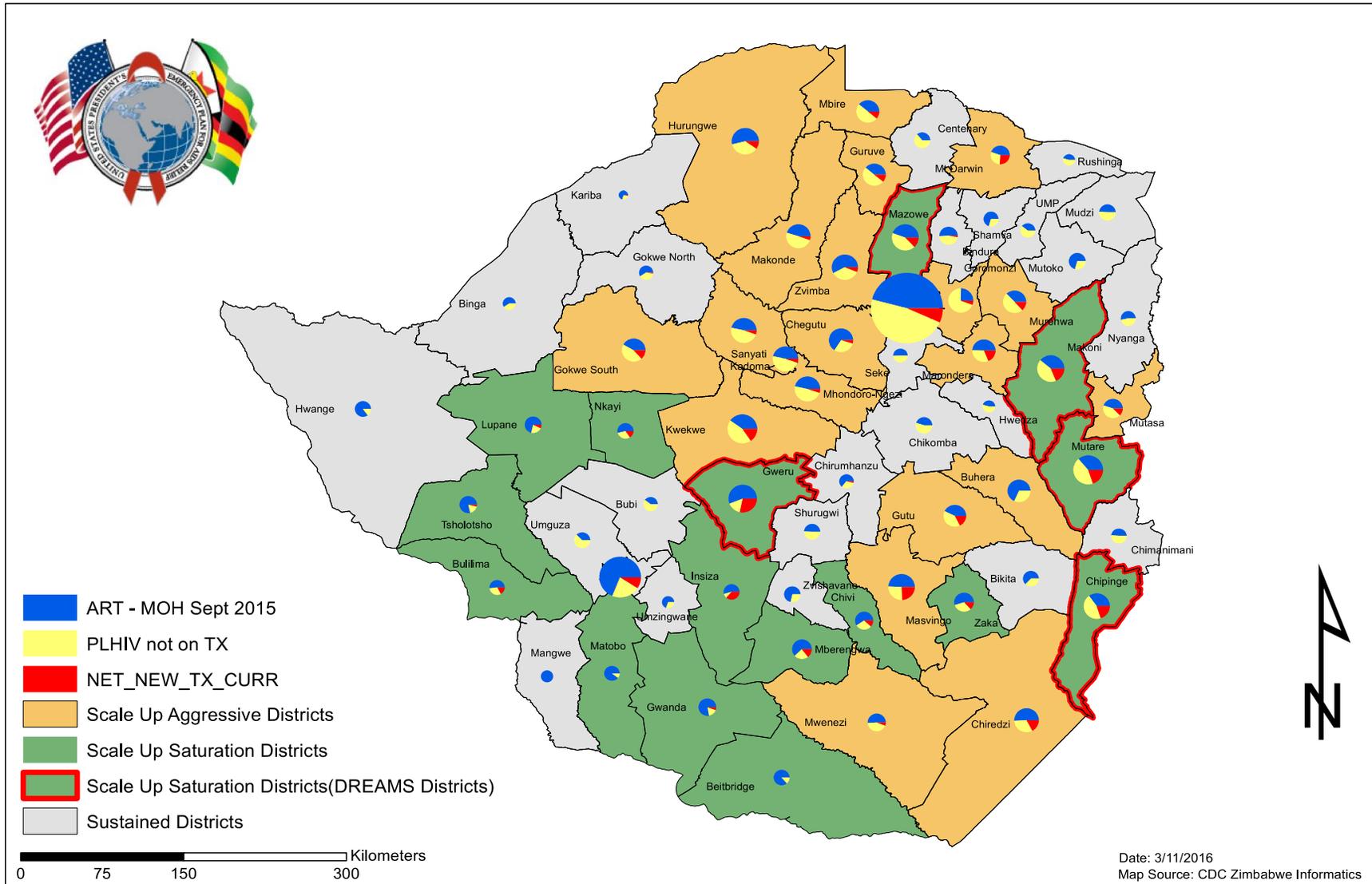
HIV Prevalence by District 2014



People Living with HIV/AIDS



Zimbabwe - ART unmet need and APR15 TX_CURR by SNU



1.3 Stakeholder Engagement

The PEPFAR team provides updates to constituents at various fora throughout the year which include: bi-monthly health development partner meetings (donors and UN agencies); national bi-annual planning and review meetings, the last of which was in January 2016 (MOHCC from all levels, civil society, NAC and private sector); CCM meetings (multi-sectoral); and MOHCC-led technical working group and partnership fora.

Host country government

Engagement with the MOHCC has continued since the Frankfurt COP Reviews. For COP 2016, initial meetings were held with the Permanent Secretary and the head of the AIDS and TB unit of the Ministry. When a COP16 planning retreat was convened in January, two representatives from the ministry attended and presented the current programs, partner contributions, key achievements and support gaps. They also actively participated in the program review and planning discussions. Thereafter, the ministry also identified one person to accompany the PEPFAR team to the DC Management meeting. Additional consultations with the Ministry of Health took place after the DC Management meeting, and representatives have been invited to attend the approval meeting in Johannesburg.

Global Fund and other external donors

Global Fund engagement has been two pronged; direct engagement with members from Geneva Secretariat, and discussions with the local UNDP office who are the Principal Recipients for the HIV grant. The U.S. government is also represented on the CCM and technical area committees, where we have taken the opportunity on several occasions to update them on the PEPFAR program. The PEPFAR team has also participated in several joint meetings with the Global Fund secretariat and the Ministry of Health to ensure an aligned message and strategy. The Health Development Partners group have been regularly updated on the COP 2015 implementation process and consulted on the COP 2016 preparation processes and strategic focus. UNAIDS and WHO, whose targets and guidelines our program is responding, were very supportive of efforts and will be represented at the Johannesburg regional review meeting.

Civil Society

Since COP 2015, the PEPFAR team has been meeting with the Civil Society Organizations (CSO) core group on at least a quarterly basis. As far as possible, documentation and data sources for each PEPFAR Oversight and Accountability Response Team (POART) have been shared ahead of the quarterly calls, and feedback has been obtained. The PEPFAR team has used each of these opportunities to share information about the COP 2016 planning process, as well as, DREAMS updates. PEPFAR shared the full slide deck prepared for the DC Management Meeting with the CSO core group representatives. Several draft versions of the Datapack have also been shared, and the team walked through the Datapack during two separate CSO core group meetings during the COP16 preparation period in March and April. Two representatives from civil society will attend and participate in the Johannesburg regional meeting in May. The PEPFAR team will continue to meet CSO representatives on at least a quarterly basis to coincide with the POART reviews.

Private Sector

Regular Private Sector engagement has been limited during the COP 2016 development process, with the exception of Global Fund CCM engagement where private sector is represented. Some discussions have occurred with individual private sector representatives around the PEPFAR program, and work continues to improve engagement with the sector.

2.0 Core, Near-Core and Non-Core Activities

The interagency PEPFAR Zimbabwe team reviewed and analyzed the following documents to determine core, near-core, and non-core activities for FY 2016: gap analyses used for the development of the revised National HIV Strategic Plan (2016-2020), the Global Fund Concept Note gap year extension and the SID. In COP 2016 PEPFAR will continue to fund key program areas in support of the national HIV response, including implementation of WHO Guidelines for Treat All and differentiated models of care, HIV prevention (through the DREAMS Initiative and VMMC), targeted testing and counseling services, OVC, lab strengthening, strategic information, and procurement of commodities including viral load. Activities described as non-core are a mixture of activities either covered by another donor or activities that do not directly support epidemic control. In COP 2016 non-core activities include HIV integrated trainings, guidelines/curriculum development, lab procurements for CD4, outreach testing in hotspots and social marketing/distribution of male condoms nationwide. For a complete list of core, near-core, and non-core activities and transition plans, refer to Appendix A.

3.0 Geographic and Population Prioritization

The PEPFAR Zimbabwe team has worked closely with the MOHCC to review epidemiological and program data to ensure Zimbabwe is on track to reach UNAIDS 90-90-90 epidemic control targets. Unmet need for ART was the most important determinant of prioritization based on 2014 National HIV Estimates. The 36 sub-national units (SNUs) identified in COP 2015 continue to represent 1 million or 80% of PLHIV. Within these 36 SNUs, PEPFAR will achieve saturation in 17 “scale-up” districts by the end FY 2017 (of which six are DREAMS districts) and saturation in 19 “aggressive scale-up” districts by the end of FY 2018. In COP 2015, the PEPFAR team expected to reach saturation in the 36 SNUs by the end of FY 2017, however, due to PLHIV estimates increasing between the 2013 and 2014 HIV estimates, a revised strategy was developed to stay on track for the 90-90-90 objectives. While the distribution of HIV remains largely the same geographically, the overall number of PLHIV increased by around 160,000. A contributing factor was the overall increase in Harare which is attributed to improved survival rates, lower mortality, and differences in population data used in SPECTRUM. To specifically address the Harare increase, the PEPFAR team will intensify its reach by implementing direct-service delivery (DSD) activities to saturate health facilities with PITC services (up from the current approximate 29% coverage), support timely ART initiation and defaulter tracing, and target key populations including FSWs as indicated in Figure 3.1.1. A DSD package of services will also be implemented across all the Aggressive Scale-up districts to accelerate the quality and depth of services to increase coverage. Additional details are further elaborated in section 4.0.

In COP 2015, PEPFAR developed a tiered package of support for Scale-Up and Sustained Districts based on the number of ART clients at PEPFAR supported facilities. In particular, PEPFAR supported 54 high volume sites (sites with ART >680 patients) in Sustained districts with a maintenance package of services including quarterly technical assistance for service delivery improvement. In COP 2016, PEPFAR will work with the MOHCC to transition support for these high volume facilities to the Global Fund and other donors to enable the PEPFAR program to intensify efforts in the scale-up districts. Facilities in the transitioned districts will fall within the “centrally supported” category; receiving lab and supply chain management support to the national system including delivery of HIV commodities.

Due to Zimbabwe’s generalized epidemic, PEPFAR will target efforts to reach high-risk and vulnerable populations as follows:

- **DREAMS:** Adolescent girls and young women (AGYW) ages 15-24 and a sub-population of vulnerable girls ages 10-14 will receive a “layered package of services” including HIV/GBV Prevention, HTS, Pre-exposure Prophylaxis (PrEP) for ages >18, access to family planning services, social protection, economic strengthening, parenting and other services to reduce HIV incidence. A Treat All Strategy will also be implemented in the six DREAMS districts to reach older men who are most likely the partners of the AGYW.
- **VMMC:** VMMC resources are being prioritized in the DREAMS and Scale-up districts to advance the 80% saturation goal among adolescent boys and young men ages 15-29.
- **Key Populations:** In COP 2016 funding will be consolidated in favor of a more comprehensive approach aimed at strengthening the clinical cascade for FSW (primary) and MSM (secondary) and reaching saturation in 5 urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. Results of a FSW size estimation are expected at the end of FY 2016, while a MSM size estimate study will be implemented in FY 2017 to further inform the KP strategy and to ensure efforts are appropriately targeted and focused in the right places.

Figure 3.1.1: Change in PLHIV Estimates (2013-2014)

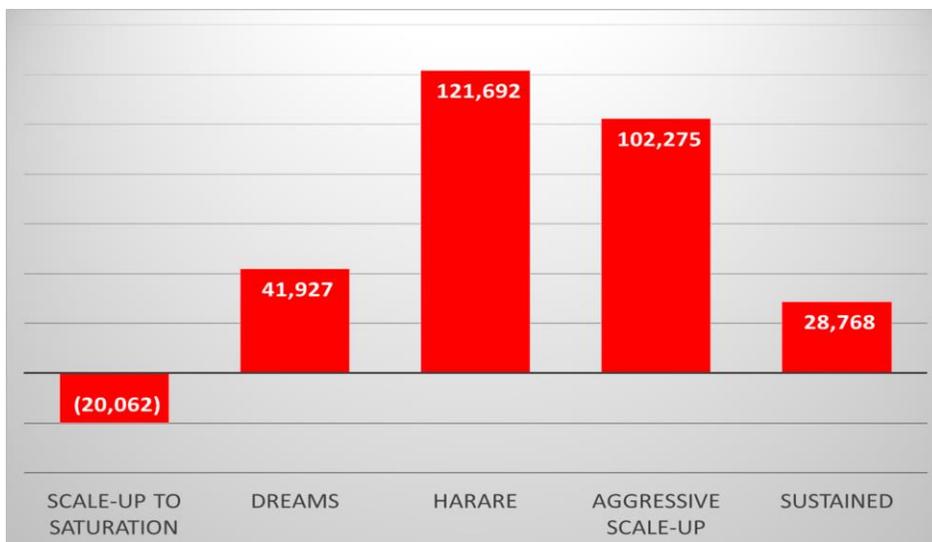


Figure 3.1.2: 90-90-90 Support Provided by District Category⁸

Package of Services	Scale-Up to Saturation	Aggressive Scale-Up	DREAMS	Harare/Chitungwiza
PITCTA	X	X	X	X
PITC (HRH)		X	X	X
Targeted outreach HTS		X	X	X
ARVs	X	X	X	X
ART initiation HRH		X	X	X
Pediatric ART attachments		X	X	X
CARGs, CATS, Back-to-care		X	X	X
Defaulter Tracking (HRH) & TB Case finding		X	X	X
Viral Load (systems)	X	X	X	X
QI	X	X	X	X
Space creation		X	X	X

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

District Type	# of Districts	Estimated # PLHIV (end of FY 16)	FY 2017 Tx_New Target	FY 2017 Tx_CURR
Scale-up (saturation)	11	182376	18,515	151,934
DREAMS (saturation sub-set)	6	308,965	75,323	264,703
Harare, Chitungwiza (aggressive sub-set)	1	291,005	51,200	165,354
Aggressive Scale-up	18	577,250	111,796	438,641
Central Support (ARV Distribution + Lab Support)	24	297,512	-	-
Total	60	1,657,107	256,834	1,020,632

⁸ “PITC TA” refers to Technical Assistance for Provider-initiated testing and counseling at the site level “PITC/HRH” refers to additional Human Resources at the site level to maximize PITC across facility entry streams; “CARGs” refers to Community Adherence Refill Groups developed from the MSF model and “CATS” is the Community Adolescent Treatment Support Model.

The PEPFAR team developed targets for ART coverage using MOHCC data for district-level disease burden (from National AIDS Estimates 2014) and demographic health information system (DHIS) data for site-level ART coverage. Epidemiological analysis during the COP2015 process showed that 80% of PLHIV in Zimbabwe reside in 36 (of the 60) districts. COP 2015 targets, therefore, were set with the goal of reaching 80% ART coverage in these scale-up districts over a 2-year period. The 2014 National Estimates, however, revealed significant variation to the number of PLHIV in many of the 36 scale-up districts as indicated in Figure 3.1.1. As a result, in COP 2016, 19 of these districts have been re-categorized as Aggressive Scale-Up SNUs with projected saturation by the end of FY 2018; the remaining 17 (designated as Scale-Up to Saturation) will be on target to reach saturation by the end of FY 2017.

Among the significant changes in SNU-level disease burden, Harare and the six DREAMS districts warrant further description. For myriad reasons, Harare has seen a significant increase in its proportional contribution to the national disease burden (from 12.3% to 17.9%) between the 2013 and 2014 National Estimates. The DREAMS districts have also seen significant increases in PLHIV, and ART coverage is of particular importance to complement ongoing HIV prevention interventions among adolescent girls and young women (AGYW). Therefore, the PEPFAR Zimbabwe team has proposed to keep the DREAMS districts within the Scale-Up to Saturation category, thereby maintaining very ambitious treatment targets in these SNUs. Furthermore, additional resources will be focused on Harare and the Aggressive SNUs, given the significant effort required to reach 80% ART coverage by 2018. As a result, the COP 2016 national target for ART initiation is 256,834. As a further refinement of the COP 2015 approach, the remaining 24 districts are now categorized as Centrally Supported. Site-level prioritization within the Scale-Up SNUs continues to be based on ART patient volume, with PEPFAR-supported sites reaching over 90% of all ART patients in these districts. These targets remain contingent upon the availability of ARVs.

Zimbabwe's MOHCC is in the process of revising the national treatment guidelines to align with the 2015 WHO recommendations to initiate ART for all PLHIV irrespective of CD4 count. This will require additional support to an already strained health care infrastructure and will further strain the ARV supply. In terms of the UNAIDS Fast Track Strategy, reaching the "first 90" requires heavy investment and strengthening of HIV testing service (HTS) strategies in order to ensure PITC is available at all service delivery points in facilities, and to refocus outreach efforts on those at highest risk.

The MOHCC has clearly indicated that gaps in human resources are a major barrier to optimizing strategies such as PITC among high-risk patients presenting to facilities. In addition, human resources are required to support targeted (e.g. outreach or index) testing strategies in the community setting. Health-seeking behavior—particularly among young men that are HIV+ but clinically well—further challenges strategies that are strictly facility-based. PEPFAR Zimbabwe will therefore support facility and community-based HTS activities through recruiting, training and deploying PITC providers to all sites in Harare/Chitungwiza. Extra emphasis will be placed on targeting children through combined PITC and contact tracing from the ART clinic as index patients. Site level support (sensitization around PITC policy, re-organization of patient flow, staff placements) to optimize facility-based PITC will continue in all of the Scale-Up districts. An anticipated consequence of the massive PITC effort is an influx of PLHIV to be initiated on ART. This will be strengthened through roving nurse teams, each of which will support 'ART Initiation

Days' at up to 5 clinics in Harare. Differentiated service delivery models will be supported where facilities are most in need of decongestion given the large numbers of ART patients.

PEPFAR Zimbabwe is anticipating approximately 28% of new initiations will come from the pre-ART population, 8.6% from the PMTCT program, 53% from facility- and community-based testing (including HIV/TB patients), and 9.5% from the pediatric population. The expected positivity yield ranges from 4% to 12% depending on the service delivery point. Progress towards the “third 90” will be supported through community-based activities on adherence and retention. In addition, PEPFAR Zimbabwe proposes to accelerate Zimbabwe’s national viral load scale-up plan. Routine viral load coverage currently stands at approximately 6%; PEPFAR is proposing to facilitate an increase to 40% coverage through reagent procurement, specimen transport, continuous quality improvement and mentorship for laboratory personnel within the existing network of “super-labs.” Lastly targeted approached will be implemented to reach hard to reach populations including men as indicated in the below table.

Based upon expenditure analysis (EA) analysis, program data from 2015, and projected costs for novel service delivery models, PEPFAR Zimbabwe has determined per person costs for facility-based technical assistance (TA), facility-based DSD, and community-based service delivery packages. This represents a different approach from the COP 15 process, where costs were determined on a per site basis regardless of the intensity of interventions provided. EA data was also used to determine the above-site and national-level costs for activities such as curriculum and guideline development and coordination support to MOHCC.

Site-level data for ART coverage (vis-a-vis PLHIV in the respective catchment areas) continues to be unavailable; PEPFAR will be working to improve data reporting and consolidation through its support for the electronic patient monitoring system (ePMS) and the development of a patient-level electronic health record. Finally, the PEPFAR Zimbabwe team anticipates a significant increase in the quality of data on HIV prevalence and incidence with the availability of two ongoing population-level surveys: the Zimbabwe Demographic Health Survey (ZDHS) and HIV Impact Assessment (ZIMPHIA). Preliminary results from the ZDHS is expected by mid-2016 and by the end of 2016 for ZIMPHIA.

Key Factors		PEPFAR Strategies for Reaching Men
<p>Sex differentials in access to/uptake of HTS and ART</p> <p>Gender norms & cultural practices contribute to poor health seeking behavior and barriers to testing</p> <p>HIV services need to be targeted to reach men most likely to be HIV+</p>	1 st 90	<ul style="list-style-type: none"> Mine & utilize existing program and survey data to better target services Expand male friendly approaches in health facilities (modify workflows at HTS entry streams to incentivize male participation, flexible clinic hours, men's health days) Optimize PITC to reach men at all entry points within the health system, including scaling up of couples testing Expand number of male lay cadres expert clients, etc. Engage existing community cadres as HTS male champions Integrate messaging which addresses men's fears of HTS Continue to invest in community outreach and mobile HTS targeting locations with high risk men; closely monitor to ensure efficacy Provide outreach HTS at strategic/convenient locations to reach more men Expand various approaches to index case testing to reach male partners Scale up HIV Self Testing
	2 nd 90	<ul style="list-style-type: none"> Prioritize men in the scale up of 'Test & Start'— build on HTS approaches that are reaching high numbers of HIV+ men Implement strategies to rapidly improve linkage from testing to treatment Immediately initiate treatment for the HIV+ partner in sero-discordant couples Explore mobile, workplace, community ART to facilitate access
	3 rd 90	<ul style="list-style-type: none"> Scale up differentiated care models that appeal to men including appointment spacing & fast tracking, CARGs, and outreach based ART distribution points

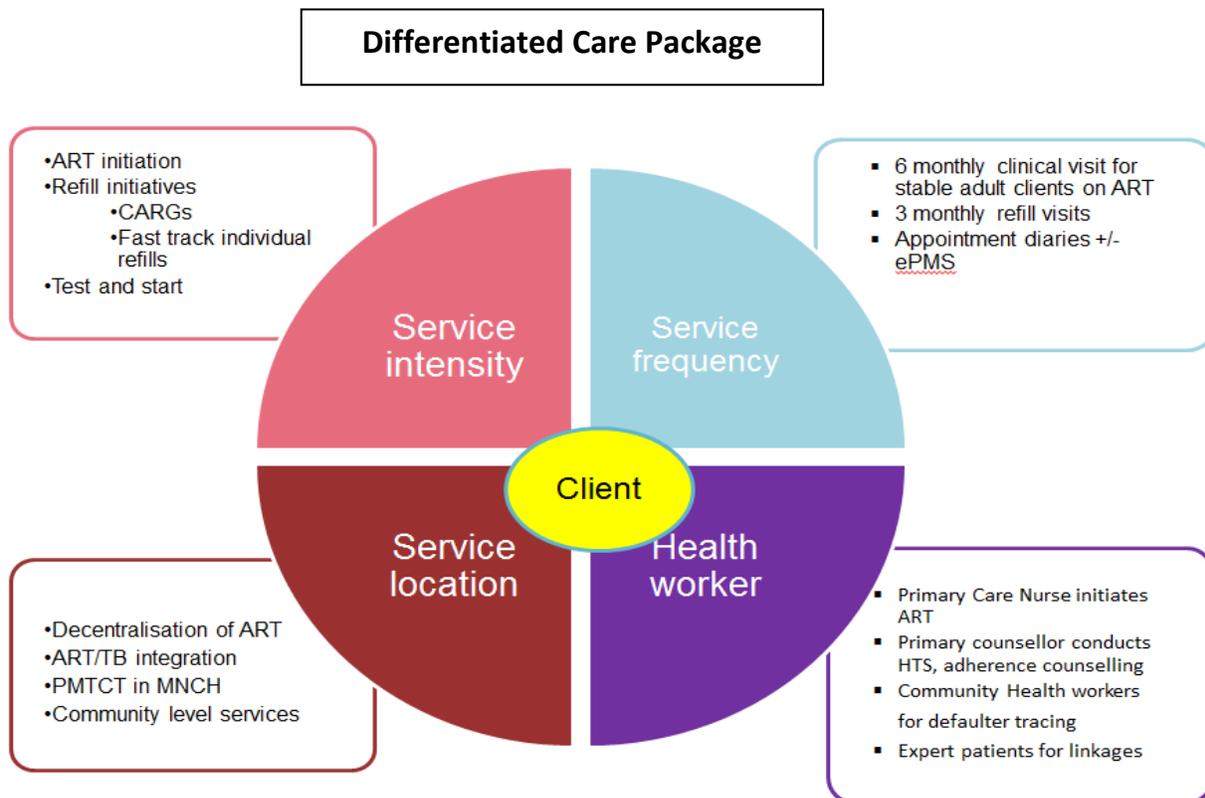


Table 4.1.1 ART Targets in 36 Scale-up Sub National Units for Epidemic Control

Saturation SNU	PLHIV Est end of FY16	Current on ART	Current ART Coverage	Target New Initiations	Target ART Coverage
Beitbridge	14,386	12,483	86.77%	895	86.8%
Bulawayo ^{*9}	96,488	75,058	77.79%	19,006	81.3%
Bulilima	13,187	9,082	68.87%	2,068	80.0%
Chipinge	37,782	20,649	54.65%	11,126	80.0%
Chivi	18,364	12,894	70.21%	2,656	80.0%
Gwanda	17,982	15,001	83.42%	1,116	86.3%
Gweru*	44,541	37,445	84.07%	7,993	84.7%
Insiza	14,386	13,132	91.28%	985	91.3%
Lupane	15,808	12,444	78.72%	1,082	80.0%
Makoni*	41,068	23,681	57.66%	10,787	84.0%
Matobo**	13,187	12,919	97.97%	861	98.0% ¹⁰
Mazowe*	39,804	22,929	57.60%	10,634	80.0%
Mberengwa	22,271	17,024	76.44%	1,785	80.0%
Mutare*	49,281	27,698	56.20%	15,777	105.5%
Nkayi	14,490	10,081	69.57%	2,251	80.0%
Tsholotsho	17,125	14,153	82.65%	1,058	82.6%
Zaka	21,189	14,261	67.30%	3,757	80.0%

Aggressive SNU	PLWHIV Est end of FY16	Current on ART	Current ART Coverage	Target New Initiations	Target ART Coverage
Buhera	29,569	20,191	68%	5,358	80.7%
Chegutu	33,100	23,373	71%	3,941	78.5%
Chiredzi	33,903	23,203	68%	5,082	78.3%
Gokwe South	31,179	17,254	55%	6,865	77.3%
Goromonzi	34,535	10,463	30%	12,757	65.2%
Guruve	29,074	14,457	50%	7,588	81.1%
Gutu	28,253	17,014	60%	4,068	75.5%
Harare	291,005	153,109	53%	51,200	56.8%
Hurungwe	41,375	26,130	63%	6,933	76.1%
Kadoma	36,410	18,790	52%	8,896	72.4%
Kwekwe	48,995	27,229	56%	8,345	76.8%
Makonde	33,100	16,763	51%	8,399	72.2%

⁹ *Indicates DREAMS District

^{10**} District serves populations from other SNUs

Marondera	29,825	20,331	68%	3,694	77.4%
Masvingo	39,554	28,986	73%	9,936	81.1%
Mt. Darwin	20,767	14,686	71%	2,836	79.1%
Murehwa	29,825	15,186	51%	4,496	72.3%
Mutasa	21,355	12,331	58%	3,218	72.3%
Mwenezi	18,364	10,480	57%	2,969	74.4%
Zvimba	38,065	24,162	63%	6,415	76.3%

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-up Sub-national Units¹¹

Entry stream in Scale-up SNU*	Tested for HIV	Identified Positive	Enrolled on ART
Pre-ART Conversion	n/a	72,198	59,211
ANC Newly Enrolled	189,836	19,033	18,083
Peds	402,334	24,089	20,008
Community sites and outreach (DSD)	132,072	15,320	142,622
PITC (TA)	1,133,989	108,445	
PITC+ (HRH)	249,622	22,776	
Totals	2,107,853	261,861	239,924

Table 4.1.3 VMMC Coverage and Targets by Age Brackets^{12*}

	Population Size Estimate (scale-up SNUs)	Coverage end FY15, expected FY16	APR 17 Target VMMC_CIRC	Expected Coverage APR 17
Males 15-29	1,611,637	14%, 22%	166,266	60%
Males 10-14	567,154	25%, 40%	70,912*	33%

*Note: COP 2016 target is inclusive of central funding; COP 16 target is 103,441 and the central funding target is 149,406. Cumulatively, 33% of boys and young men 15-29 years will be circumcised by APR 2017 in scale up SNUs; APR 2017 target is number of men of this age group circumcised.

¹¹ In COP 2015, it was estimated that approximately 28.8K individuals would be tested for HIV in TB clinics. The number of TB cases with unknown HIV status is about ~3,000. In COP 2016 TB/HIV is a subset of the PITC (TA) and PITC (HRH) entry streams.

¹² An additional 15,670 males older than 30 years will be circumcised to bring the total VMMC target for COP 2016 to 252,8481. No boys younger than 10 years will be circumcised

Table 4.1.4 Target Populations for non-ART HIV Prevention Interventions to Facilitate Epidemic Control**

	Population Size Estimate (scale-up SNUs)	Coverage goal	APR 17 Target
AGYW 15-24 years (PP_PREV)	243,224	25%	83,053
Female Sex Workers (KP_PREV)	13,504	-	10,800
MSM (KP_PREV)	-	-	1,662
Boys and young men 15-29 years (VMC)	1,611,637	33%	166,266
Total	1,868,365		263,781

**Note: APR 2017 target for AGYW is PP_PREV in DREAMS districts. Size estimate of FSW population in focus locations is based on 2% of female population 15-40, as survey based size estimation data is not yet available. There is no size estimate for MSM in the focus locations.

Table 4.1.5 Targets for OVC and Linkage to HIV Testing, Care and Treatment

SNU 2	Estimated Number of PLHIV Under 15	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	Target OVC coverage
Buhera	3,458	24,588	23,875	97.10%
Centenary	1,532	12,279	5,500	44.79%
Chegutu	3,257	27,184	26,852	98.78%
Chipinge	4,419	32,413	27,320	84.29%
Chiredzi	3,937	30,621	9,010	29.42%
Goromonzi	3,274	29,583	21,476	72.60%
Gutu	3,281	20,308	20,000	98.48%
Gweru	4,230	24,967	12,471	49.95%
Harare	21,768	217,981	68,227	31.30%
Insiza	1,290	10,033	9,299	92.68%
Kadoma	3,449	30,971	9,500	30.67%
Makonde	3,257	31,147	28,776	92.39%
Makoni	4,803	30,266	29,430	97.24%
Mazowe	4,195	24,400	16,893	69.23%
Mutare	5,763	44,975	38,813	86.30%
Mutasa	2,497	16,875	16,211	96.07%
Zvimba	3,746	26,302	14,794	56.25%
TOTAL	78,156	634,893	381,733	60.13%

4.2 Priority Population Prevention including Key Populations

Estimating the size of *key populations* (KPs) in Zimbabwe has been challenging, particularly among female sex workers (FSW), men having sex with men (MSM), transgender persons (TG) and people who inject drugs (PWID). A size estimation and retention/clinical cascade of care study is currently underway for FSWs with results expected in September 2016. The protocol for the PEPFAR-funded MSM size estimation is still under discussion. Under the current U.S. government policy environment, PEPFAR is unable to support any activities in prisons (these activities are funded by DfID, GF and NAC). According to recent estimates from respondent driven surveys (RDS) supported by CeSSHAR suggests that the estimated number of FSWs nationally is between 40,000-80,000. The current 'best' estimate for HIV prevalence among FSWs is 57.5%, derived from a 2013 baseline survey of 2,722 FSWs in 14 sites participating in the SAPPH-IRe trial. HIV prevalence among MSM is estimated at 23.5% based on 2013 research carried out by Biomedical Research Training Institute in collaboration with GALZ and NAC.

In 2011, a mapping of hotspots of FSWs was undertaken and as a result, the national FSW program, 'Sisters with a Voice,' was scaled up to include 6 static sites and 36 outreach points services in 30 districts, four of which lie outside the 36 scale-up districts and include Bindura, Kariba, Hwange and Zvishavane. The national FSW program has been designed to improve access to HIV prevention, care and treatment services acknowledging that FSWs are a highly-stigmatized group who are reluctant to seek services through public health facilities.

In COP 2015 HIV prevention activities were prioritized to better target highly vulnerable groups in the 36 scale-up districts and four hotspots districts. Targeted priority populations included AGYW 15-24, who have a 1.5 times higher HIV prevalence than their male counterparts, and adolescent boys and young men age 15-29 with a focus of linking this group to VMMC, HTC, and care and treatment services. Other priority populations include sero-discordant couples, men and women aged 15-49 years in hotspots such as mining areas, migrant workers, and growth points where populations have limited access to HIV services.

In COP 2016 a strategic decision was made to consolidate funding and make major shifts towards a more comprehensive and focused approach for KP. Through expanded support of the national FSW program (Sisters with a Voice), and collaboration with community-based FSW networks, PEPFAR will emphasize the identification of new targets and strengthen the clinical cascade among FSW in 5 urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo (a population of 13,500, representing 20-37% of national total of ~40,000-80,000). This new strategy will employ proven approaches for reaching, testing and immediately initiation of ART for HIV+ FSWs. The program aims to increase knowledge of HIV+ status to 90% of FSWs living with HIV, 90% ART uptake among those with known HIV+ status and 85% viral suppression among those on ART. All HIV+ individuals will be enrolled at New Start KP treatment sites that offer a one-stop shop for health care (HTS, STI, FP, cervical cancer, post GBV care, ART, TB, and lab) and provided with viral load monitoring at 6 and 12 months. Continuous adherence and retention support will be offered through the Sisters peer adherence support groups. Once viral suppression has been demonstrated, patients will be transferred to public sector for ongoing ART provision at KP friendly sites. Delivered through a peer education (PE) approach, HIV prevention (male/female condom and lubricant distribution, risk reduction counseling and referral for HIV/STI/SRH clinical services), will be a core component of the strategy. A variety of entry points (FSW networks and support groups, bars, beerhalls, hair

salons) will be targeted in an effort to reach both self-identifying and 'hidden' FSWs who have had no or limited exposure to HIV services. The program will leverage DREAMS and UNITAID funding to make PrEP available for all HIV negative FSWs. Identification, linkages between community and facility services, and follow up of SWs has been a weak component of the program, and will be strengthened through the use of unique identifier codes and screening tools.

The median age of entry into the Sisters program is 27 years, however program and survey data suggest that 25-40% of FSW are less than 23 being, with the median age of those starting sex work (among current FSWs) and more than a quarter starting before age 20. Young FSWs report the highest numbers of unprotected sex acts with clients. They report more frequent HIV testing but they are the least likely to know they are HIV+. HIV prevalence among young sex workers is approximately 30%, rising to nearly 80% among those over 40; prevalence rises with duration in sex work among young FSWs. Building on the work underway in DREAMS districts, efforts will be made to identify new and younger FSWs through an adaptation of the Sisters PE program specifically designed for this very hard to reach population.

Following discussions with civil society, in COP 2015 PEPFAR strengthened linkages with local civil society partners supporting the MSM community. Activities include training of PEs in risk reduction strategies, training providers to be MSM and TG friendly, facilitating access to HTS, ART and VMMC and introducing distribution of centrally procured lubricant.

In COP 2016 PEPFAR will support local KP community-based organizations to lead the response. PEPFAR will work closely with the organization Gays and Lesbians of Zimbabwe (GALZ), and the Sexual Rights Center to reach 1,662 MSM in the 5 KP focus locations of Harare, Bulawayo, Gweru, Mutare and Masvingo. Interventions to strengthen the clinical cascade will be emphasized with the goal of increasing knowledge of HIV+ status to 90% of those living with HIV, 90% ART uptake among those with known HIV+ status and 85% viral suppression among those on ART. The program will identify peer educators (PEs) in major towns in addition to those already trained in Harare and Bulawayo. PEs will be trained to conduct IPC sessions on risk assessment and reduction, condom use and referral into HTS and other high impact clinical services. Condoms and water-based lubricant (procured through central commodity fund) will be distributed. The use of social networking platforms, including WhatsApp and Facebook, will be explored to increase access to HIV information and services. The program will provide HTS, ART, STI management and viral load monitoring at 6 and 12 months for MSM at New Start Centers. HTS will also be offered through outreach at GALZ and other convenient locations/times including evenings and through smaller MSM groups. MSM on ART will be encouraged to disclose their status and have treatment buddies for adherence support. MSM groups will also be supported to establish community adherence activities. As part of site level support, PEPFAR will collaborate with MSM networks to develop a plan for clinical partners and MSM networks to provide MSM sensitization and competency training.

Prevention activities funded under COP 2015, including National social marketing and interpersonal communication (IPC) for male and female condoms, will be scaled down except for those targeting KPs in the five locations as described above. Through USAID's Central Procurement mechanism, headquarter operational funding (HOP) will be used to procure 104,0370,000 public and private sector male condoms and 6,324,000 public and private sector female condoms. COP 2016 leveraged funding to support condom programming for the general population and in four hotspots outside the priority districts will be discontinued. Although

resources will be maintained for condom social marketing for Key Populations, PEPFAR is coordinating with the MOHCC and other donors to identify alternative sources of funding for this important program. Zimbabwe has demonstrated consistently high condom use; previous DHSs have found condom use by men at last sex with a non-marital, non-cohabitating partner to be 70.2%, 70.9%, and 77.3% in 1999, 2005, and 2011 respectively. This is one of the highest condom use rates found within the region and is believed to be a contributing factor in the decline in HIV prevalence reported in Zimbabwe.

In COP 2016 non-PEPFAR funding will be used to procure lubricants, male and female condoms through the central commodity fund. They will be distributed to health facilities where they will be provided free of charge to the public via the national (PEPFAR-supported) commodity distribution system that delivers other HIV related drugs and commodities. Implementing partners will also distribute condoms.

HIV prevention remains an integral component of other technical areas e.g. PMTCT, HTS, VMMC, ART and a comprehensive package of activities include: targeted risk assessment and provision of risk reduction information; condom promotion, condom skills training and distribution; and information about and active referrals to clinical services as appropriate. In COP 2016 men age 15-29 are highlighted as a priority population for prevention due to their importance in controlling the HIV epidemic in Zimbabwe.

DREAMS is an integral part of the overall PEPFAR strategy in Zimbabwe, ensuring existing OVC, HTS, VMMC, ART and facility and community based care and treatment activities are well targeted, complementary and reach deeply into the DREAMS focus populations. In COP 2016 DREAMS will be PEPFAR's core HIV prevention program in Zimbabwe, operating in six of the 36 PEPFAR scale up districts. Zimbabwe is implementing the full DREAMS package including, in and out-of-school based HIV prevention, community norms change, HTS targeting AGYW 15-24 and their male partners, condom distribution, family planning outreach, GBV prevention and response, education subsidies and cash transfers targeting AGYW 10-24 in labor constrained and food insecure households, parenting education and household economic strengthening to parents/caregivers of highly vulnerable girls, and expansion of PreP and HIV prevention targeting young women selling sex. District level microplanning and hot spot analysis is underway to effectively target program activities. In COP 2016 a follow on VAC survey, locally known as YAZ (Young Adult Survey of Zimbabwe) will also be carried out as part of DREAMS. Zimbabwe is benefiting from supplementary Test & Start and VMMC funding to rapidly expand access of male sexual partners of AGYW to high impact HIV services in the DREAMS districts. DREAMS is coordinated by the NAC structure, including at the provincial (PAC) and district (DAC) levels, to ensure broad participation by the different sectors, service providers and other stakeholders (including young people) that make up the DREAMS approach.

The Gender Analysis documented several issues that influence HIV prevention. These include lower utilization of HIV services among men, high prevalence of GBV, numerous gender, cultural (and religious) practices and norms that can fuel HIV transmission and/or treatment avoidance, and persistent stigma towards KPs in the healthcare setting. Findings will be used to design new, as well as to fine tune existing program activities including male and adolescent friendly services; GBV screening, counselling and referrals in ART services; availability of male lay/peer cadres for counselling; psychosocial support for groups that may have particular challenges with lifelong ART (children & adolescents, GBV survivors, individuals from conservative religious groups); and

rights based training that promotes accepting and positive attitudes towards adolescents, SWs, MSM. Partners will work closely with traditional and religious leaders who have significant influence in changing harmful gender and social norms. Community leaders are also critical in promoting positive health seeking behavior such as uptake of HTC, VMMC, PMTCT and adherence to ART and retention in care. Involvement of community leaders in outreach activities will be critical for success and PEPFAR partners will work closely to engage these community gatekeepers.

Based on Site Improvement for Monitoring Systems (SIMS) visits, the weakest component of current HIV prevention activities remains the linkages to HTC, VMMC, and care and treatment service delivery. Innovations recently introduced include a unique identifier for FSW programming. A similar system will be employed with the DREAMS program. Strategies to improve linkages including active tracking of referrals, peer navigation to services, SMS reminders and development of revised community to facility referral tools will be scaled up in COP 2016.

4.3 Voluntary medical male circumcision (VMMC)

Among the 14 VMMC priority countries, Zimbabwe has the potential to avert the highest proportion of new HIV infections with VMMC. Recent modeling suggests that as few as 5-12 circumcisions will avert one new HIV infection and circumcising 1.9 million Zimbabwean men aged 15-49 by 2017 will avert 240,000-310,000 new infections by 2030 (30% of all new infections)¹³. It was further estimated that 4,000-8,000 infections have already been averted between 2009 and 2015, which in turn will prevent as many as 75,000 new infections by 2030 (10% of all new infections). Earlier modelling suggests that prioritizing Zimbabwean males aged 15-29 will lead to the greatest reduction in HIV incidence in the short-term and inclusion of the 10-14 year age group provides the greatest magnitude of impact after 15 years¹⁴.

In 2009 the MOHCC launched their flagship VMMC program targeting 13-29 year olds. In 2014 a new accelerated VMMC plan (2014-18) was developed with a shift in target age group to 10-29. Through December 2016, there have been 621,811 circumcisions towards a national target of 1,300,000. PEPFAR VMMC support started in 2009, but has scaled up since 2013 upon receiving additional central funding. The national program remains in a “catch up” or accelerated phase due largely to limited financial resources.

At present the national VMMC program is operating with support from PEPFAR, BMGF and DfID in those districts where donor funding targeting. In COP 2015 the number of districts offering VMMC with PEPFAR funding was reduced to 33 from 60. Transition to the 33 districts was completed by December 31, 2015. Eighteen districts previously supported by PEPFAR have been since included in a recently approved program by the Bill and Melinda Gates Foundation (BMGF). BMGF will fund all service delivery, including demand creation, and commodity costs for circumcision in these districts. BMGF also supports national level communication activities (e.g. the IPSOS research) and provincial level technical officers through a grant to the Clinton Health Access Initiative. USAID policy restricts certain kinds of direct support to GoZ and as a result, DfID funding contributes to the MOHCC cost reimbursement component in 25 USAID districts.

¹³ Summary of Results from Model Applications, John Stover, Avenir Health, December 2015.

¹⁴ <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001132>.

With the exception of bridge funding availed in FY 2016 in a limited number districts moving from PEPFAR to BMGF, DfID funding is directed to USAID districts. In these 25 districts, DfID and USAID funding is effectively combined and separate targets are apportioned to each donor according to its level of budget support. DfID funding covers all of the portion of the GoZ cost reimbursement scheme considered direct government support, and USAID pays for a greater portion of other service delivery costs. With this leveraging arrangement, outputs are funded proportionally to each donor's contribution, and consequently the PEPFAR reported EA unit expenditure is a true reflection of the actual cost per circumcision. The Global Fund is currently providing PrePex commodities for the national VMMC program, but not service delivery.

In FY 2015, PEPFAR carried out 156,215 circumcisions, 94% of the target of 166,500. In FY 2016 Q1 the program had met 25% of its annual target of 190,194.

In COP 2016 PEPFAR will continue to advance the age pivot focusing demand creation and supply on the 15-29 year age group. In FY2016 Q1, 53% of PEPFAR results were in the 15-29 age group; in COP 2016 at least 62% of circumcisions will be in the 15-29 age group. In this age group either the forceps guided method or PrePex (under a passive surveillance approach) will be used in COP 2016. Demand for PrePex continues to increase with 3,000- 3,500 procedures/month during FY 2016 Q1. While emphasis will be on reaching the 15-29 year olds, services will not be withheld from any medically eligible man. Circumcisions in boys younger than 15 will be carried out using the dorsal slit method. In FY 2015 the training of new MC providers and re-training of current providers in the dorsal slit method was completed. The program will extend PrePex to men age 13 and above based on the recent WHO Field Safety Notice. PEPFAR funding will not be used to circumcise clients younger than 10 years.

An external quality assessment (EQA) was carried out in December 2015 which showed the Zimbabwe program to be of high quality. While the program generally scores well for SIMS, one third of assessments in FY 2015 and FY 2016 Q1 scored low the Adverse Event and Prevention Management CEE; in particular these sites scored red for having an incomplete crash cart. The importance of having a fully stocked crash cart has been emphasized to IPs and will continue to be monitored going forward.

In COP 2016 PEPFAR commodity funding will be used for surgical kits and commodities in PEPFAR districts only. National costing assumptions for commodities now reflect the age pivot and increasing proportion of PrePex procedures among men age 13 and above. Cost reimbursements for VMMC follow PEPFAR's Best Practice for VMMC Site Operations guidance; the reimbursement plan was revised in 2015 to account for type of procedure, location and service delivery approach—resulting in cost savings in COP 2016. A site capacity utilization assessment has been piloted and will be completed in COP 2016 to adjust supply of services/providers to demand. PEPFAR will provide limited national level technical support (e.g. staff time) for planning for the national maintenance phase. An Integrated Primary Facility PrePex service delivery model will be piloted to ensure lower cost at community level over time.

For demand creation, COP 2016 will focus on strengthening interventions targeting the 15-29 year age group based on extensive research conducted by IPSOS in 2015 (funded by BMGF). New messages, channels and interventions of both IPC and mass media will be developed using human centered design approaches. Examples include conveying honest communication on pain, procedure and healing; converting past clients into champions; and targeting mass media

campaigns to promote PrePex, which according to the IPSOS market research, presents an opportunity to better engage the 15-29 year olds. IPC agents will be trained in a phased approach in order not to disrupt service delivery. Innovative approaches including offering mobile services to congregate settings in urban areas and use of mobile technology and social media will be pursued.

In COP 2016 PEPFAR, in collaboration with MOHCC and implementing partners, revised the VMMC UE to account for a number of efficiencies that will be implemented to reduce costs including: cost savings based on revisions to the MOHCC cost reimbursement plan, increasing proportion of circumcisions performed at the lower levels of the health system (note all circumcisions are already performed by nurses), and increasing proportion of PrePex procedures. In addition the national VMMC program commodity list was updated and revised with current pricing for kits and other consumables and cost savings from planned efficiencies in the commodity distribution system were identified. The PEPFAR team will continue to monitor expenditures to ensure that the reduced UE does not impact the country's ability to reach targets.

With COP and additional central funding, at the end of FY 2016 13 districts are expected to reach more than 80% coverage among the 10-14, age group and 5 districts among the 15-29 year age groups.¹⁵ PEPFAR has set a target of 103,441 for COP 2016 and will be requesting central support to reach an additional 149,406 men. Targets were allocated to districts based on past performance and potential to efficiently deliver results. Accelerating coverage in DREAMS districts was also prioritized, as well as reaching at least 62% of targets in the 15-29 year old age group—an ambitious but feasible proposal assuming the revamped demand creation strategy is successful.

4.4 Preventing mother-to-child transmission (PMTCT)

Throughout 2014, Zimbabwe implemented a national roll-out of Option B+. Now, over 1,500 health facilities across the country now function as PMTCT/ART sites. Uptake of PMTCT services has been extremely strong and data from the 2014 PMTCT Effectiveness Survey revealed an MTCT rate of under 7%, compared to 30% reported in 2011. There are, however, aspects of the program warranting additional support. Efforts to reach male partners with testing and treatment services have not been particularly successful. Additionally, while early infant diagnosis (EID) is generally available in all facilities, delays in returning results to facilities and to the mothers and overall coverage of EID services remains suboptimal at around 58%.

The PEPFAR Zimbabwe team will leverage Global Fund support for EID commodities in order to focus resources on improving program implementation and M&E. Among other efforts, finalization and widespread implementation of mother-baby tracking tools will improve information management and linkage into care for HIV-infected infants. To achieve epidemic control, PMTCT program targets were set to reach 95% of pregnant women with HTS and initiate 95% of those tested on ART in the 36 scale-up districts. The MOHCC is in the process of developing a phased implementation of the WHO 2015 guidelines for Test & Start and support for this process is expected to improve the uptake of HIV services among the male partners of

¹⁵ VMMC targets by age and district for Zimbabwe—a preliminary exploration, Project SOAR, February 2016.

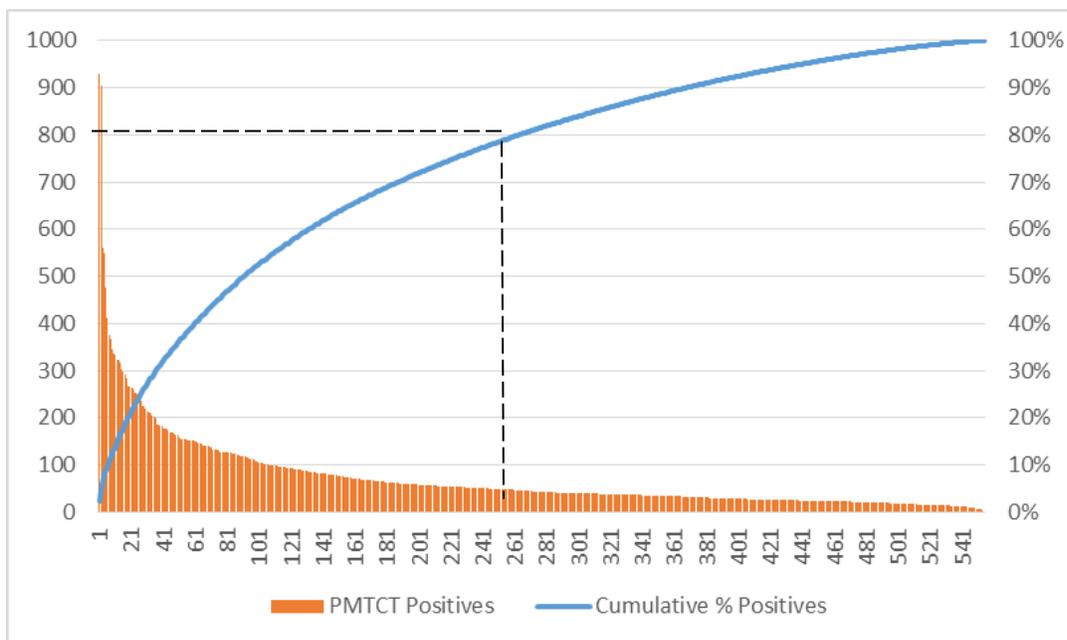
PMTCT clients during FY 2017. Expanding on DREAMS-related initiatives begun in FY 2016, PEPFAR Zimbabwe will implement facility and community-based strategies to reach male partners with HTS and ART services (details under Section 4.8). Preliminary data from the 2016 PMTCT Effectiveness Survey will provide extremely valuable information on the MTCT rate throughout the breastfeeding period.

PEPFAR will continue to support the national PMTCT program in its commitment to validate the elimination (< 5% transmission) of mother to child transmission of HIV as a public health problem. Building on already existing U.S. government investments (strong coordination forums, well trained facility staff, functional commodity management systems etc.), the PEPFAR team will support activities to improve quality and expansion of coverage of HIV interventions in maternal, neonatal and child care service platforms. Support will also be maintained to strengthen national monitoring and surveillance systems to capture and process data on the achievement and maintenance of the validation indicators. PEPFAR partners will utilize mobile outreach and initiation units in DREAMS districts will also be leveraged to identify HIV positive pregnant mothers not presenting to ANC due to distance, cultural and/or religious beliefs which may prevent them from seeking health services.

Efficiency Analysis

APR 2015 data, reflected in Figure 4.4.1 below, revealed that 41% of sites (620) identified 80% of HIV-positive individuals (49,790) with 15 sites finding zero positives and 93 sites identifying <4 positives. Eighty percent of individuals identified as positives were tested in sites within the 36 scale-up districts. The PEPFAR team will review the sites to determine if there are systemic issues with implementation or if the sites are new as a result of decentralization.

Figure 4.4.1 Newly Tested HIV-Positive Pregnant women in ANC (APR 2015)



4.5 HIV Testing and Counseling (HTC)

The PEPFAR Zimbabwe team has been working with the MOHCC to develop a new National HTS Strategy, emphasizing high yielding approaches based on the 2015 WHO HTS Guidelines. In determining core, near-core, and non-core activities for COP 2016, the PEPFAR team considered the activities necessary to achieve epidemic control, the current and expected future investments from all stakeholders, and the unique position of PEPFAR to provide direct service delivery and technical assistance for HTS. Focusing on scale up districts, PEPFAR investments will:

- Strengthen PITC across multiple entry points at health facilities;
- Provide community HTC services through strategically located static and outreach service points, targeting high yield populations and locations, with an intensified focus on AGYW and their male sex partners, as well as KPs;
- Expand index case and family testing in the community;
- Expand programs that provide incentives for men to get tested while ensuring gender stereotypes are not perpetuated in the process;
- Ensure that all HTS includes TB screening, as well as, approaches to actively link those testing positive into treatment, and those testing negative into and prevention services such as VMMC.

In COP 2016 community HTS in hot spots located in centrally supported districts will be eliminated, however HTS will continue to be provided by implementing partners with non-PEPFAR funding. Common issues identified across facilities during SIMS include inconsistencies in rapid test kit (RTK) quality control, insufficient referral and tracking documentation and low linkage rates. All issues are being addressed through remedial action plans and review during repeat visits (e.g. ongoing mentoring of facilities on importance of running quality control samples and registering results at appropriate times). Strengthening linkages between facility and community, through the development of improved tools and SOPs, is a major focus in COP 2015 and will remain so in COP 2016.

Data from APR 2015 indicated that more women (60%) accessed testing services than men (39%). The Gender Analysis documented several factors that could impact HTS uptake including preponderance of female-biased health services, high prevalence of GBV, cultural (and religious) practices and norms that can fuel HIV transmission and/or HTS avoidance, and persistent stigma towards KPs in the healthcare setting. In COP 2016 findings will be used to design new, as well as fine tune existing, program activities to address gender disparities in HTS, as well as, low coverage of HTS among KPs and adolescent girls. Index case testing will also be expanded, in both facility and outreach settings. Outreach HTS will be targeted in order to most efficiently reach larger volumes of undiagnosed HIV+ men, AGYW and KPs. Approaches to make testing more male and adolescent friendly include implementing flexible clinic hours; GBV screening, counselling and referrals; availability of male lay/peer cadres for counselling and peer navigation; and rights based training that promotes accepting and positive attitudes towards men, adolescents, SWs, MSM in the healthcare setting. PEPFAR will also leverage UNITAID funding in DREAMS districts to offer self-testing as an option for populations that have shown reluctance to test.

Data from multiple sources (ZDHS, ZIMPHIA, male characterization study of HIV+ AG, and YAZ/VAC 2016) will be used during COP 2016 to more strategically target HTS approaches to AGYW and their male sexual partners. HTS efforts in COP 2016 will continue to focus on maximizing yield and identifying high numbers of undiagnosed positives; a trajectory set in COP

2015. HTS service delivery approaches were determined based on ART coverage gaps in specific SNUs. DREAMS districts are also prioritized for more intensive support.

- In Scale-Up to Saturation SNUs, PEPFAR will provide site level technical assistance for service delivery improvement (TA-SDI) and mentoring to optimize PITC. Given the large gap in pediatric ART coverage, PEPFAR will support PITC+ (additional HR provided) and community approaches for pediatric testing.
- In the remaining districts Aggressive, DREAMS and Harare/Chitungwiza, PEPFAR will provide site level DSD interventions including surge primary counselor HRH in facilities, to optimize PITC, index testing, ART initiation teams, community adherence and retention groups, and outreach community testing—both for identifying adults living with HIV and to scale- pediatric ART coverage.

The COP 2016 yield target for PITC ranges from 8.5 – 14.5% based on historical and projected SNU specific data. The yield target for community HTS is 11.6% (as in COP 2015). To achieve epidemic control, accelerated identification of more HIV+ individuals is imperative; therefore program data (including GIS technology) will be regularly monitored to better target high yielding geographic areas and populations. All newly diagnosed will be linked to treatment, offered assistance to disclose to partners, and encouraged to facilitate index case testing for sexual partners and children using a variety of means. In health facilities, PITC will be fully optimized through continuous site level TA-SDI and mentoring. A new PITC+ strategy which adds lay cadres in facilities with human resources shortages will be employed in all scale up districts to increase coverage of pediatric testing, as well as in selected districts to increase PITC among adults. Index testing will be delivered through key entry points such as ART, PMTCT, TB, and STI, as well as through community outreach. Static and outreach based community testing will target high-yield populations in selected geographic locations; ongoing data monitoring will allow for rapid course correction. Static and outreach based community testing will also be employed for pediatric HTS.

With leveraged funding from UNITAID, HIV Self-testing (provider led, or take home) will be used as a testing for triage strategy (to increase yield) and to reach populations that would otherwise not test for HIV using current methods (SWs, MSM, men and adolescents) in DREAMS districts. The promotion of HTS among OVC will continue in COP 2016, with the addition of a screening tool to limit testing to those children most likely to be HIV+. Treat All is underway in six DREAMS districts, with full roll out expected in early FY 2017.

As mentioned in Section 4.2 PEPFAR will consolidate funding and make major shifts to a more comprehensive and focused approach for Key Populations. Through expanded support of the national SW program (Sisters with a Voice) PEPFAR will emphasize the identification of new targets and strengthen the clinical cascade among Sex Workers (primary) and MSM (secondary) in five urban locations with high numbers of SWs. A peer education approach, delivered through multiple entry points (SW networks/groups, hair salons, bars), will be utilized to reach SWs, while new MSM will be identified primarily through partnerships with GALZ and the Sexual Rights Center. HTS will be provided through the Sisters SW clinics, New Start clinics and through outreach including moonlight testing. All newly diagnosed KPs will be initiated on ART immediately at New Start centers or the public sector health facilities that have received 'KP friendly service' training.

Outreach Site Yields FY16 Q1¹⁶

N= 32,652 (65% of total tested in Q1)		
Outreach Site Classification	(Percentage of total)	Yield
Rural business centre	28.9%	8.0%
Urban business centre	17.8%	6.2%
Commercial Farm	13.0%	8.9%
Resettlement farm	7.4%	10.2%
School	7.2%	9.2%
Workplace (excluding mines, market place & farms)	5.8%	5.4%
Bus Terminus	4.1%	5.9%
Market place	3.3%	8.1%
Formal Mine	2.8%	6.7%
Urban Residential area	2.1%	8.8%
Artisinal Miners (makorokoza)	2.0%	7.7%
Household	1.6%	6.8%
Church	1.1%	5.8%
Health Facility	1.0%	11.0%
Community Meeting area	1.0%	10.4%
Informal Settlements	0.4%	9.2%
Feeding place for the displaced	0.2%	21.1%
Females answering yes to Q on exchanging money/goods; total tested in both static & outreach was 322)	0.1%	66.7%

Based on the analyses, in COP 2015, both facility-based and community HTC activities will be focused within the 36 scale-up districts. In scale-up districts, 1,461,569 people will be tested through multiple entry points (see Table 4.1.2) resulting in 153,030 newly identified HIV-positives clients. PEPFAR will also support PITC at high volume maintenance sites in 24 maintenance districts and expects to support through technical assistance an additional 100,328 tests.

HTC strategies will focus on better targeting vulnerable groups and key populations where higher positive yields (above 9 percent) are expected with stronger linkages of clients to care and treatment services. PITC in ANC is already well established with 97 percent uptake; however, HIV testing on in-patient wards, nutrition rehabilitation units and during general outpatient visits remains weak. Technical assistance will focus on strengthening testing in these areas.

For voluntary testing and counseling (VCT) activities and community based testing, PEPFAR will support direct service delivery for testing at fixed New Start sites in the scale-up districts and

¹⁶ Source: PSI FY16 Q1 Program Data

¹⁷ In Quarter 1 of FY16, 28,029 HIV-positives were cumulatively identified, 1 site identified zero

community outreach testing services to at-risk and vulnerable populations¹⁸. The targeted groups will include SWs, MSM and both men and women, aged 15-49 years, in “hotspots” such as mining areas, migrant worker communities, growth points, and communities along the major transportation corridors¹⁹. Other priority groups for HTC include AGYW ages 15-24, who have a 1.5 times higher HIV prevalence than their male counterparts. Within districts, mapping of high risk and vulnerable groups through TRAC surveys, and analysis of a UN “hotspot” analysis will support plans on where to conduct HTC outreach activities. Different modalities such as index tracing will also be scaled up, linked to the community care and support outreach activities where higher yields are also expected. HTC services will be provided during VMMC campaigns targeted at 15-29 year old adolescents and through VMMC outreach. Analyses for all testing service modalities and for PITC sites will be refined on an on-going basis to better focus testing activities toward locations and modalities that produce the highest yield of HIV positives.

Sites identifying less than 4 positives (such as churches and rural business centers) will not be funded in COP 2016. PEPFAR will continue to distribute HIV test kits to all facilities using DfID leveraged funds. Community leaders, other community members, and families are critical in promoting positive health seeking behavior such as uptake of HTC, VMMC, PMTCT and adherence to ART and retention in care. U.S. government partners will work closely to engage these community gatekeepers for increased uptake in HTC services. Other efforts through strengthening the Social Welfare case management systems for children described under the OVC section will also be applied to support greater access to HTC services and linkages into care.

The MOHCC allocates minimal funding to support HIV prevention activities, including HTC services. The primary funders for rapid test kits have typically been PEPFAR (emergency gaps), GF, NAC, and occasionally UNFPA and AXIOS. PEPFAR will continue to work closely with the MOHCC to determine gaps in HTC, provide technical assistance to support national resource mobilization efforts from all funding sources, and harmonize HTC activities at national, facility and community levels to increase efficiencies and coordination. Test kits will not be procured using COP 2016 funding except to cover emergency gaps. The GF, NAC and other donors will continue to fund RTKs and identify ways to mobilize resources for an estimated \$3.43 million gap for 2016. Through DREAMS, an additional 235,000 AGYW will be tested.

4.6 Facility and Community Based Care and Support

Community-based care and support activities are crucial to ensuring adherence to therapy and retention within treatment programs. With a case load of ART patients approaching 850,000 (program data, Sep. 2015), epidemic control will depend increasingly on ART retention, rather than initiation alone. In order to increase access to and retention in care, the MOHCC has incorporated the concept of differentiated service delivery packages within its Operational Service Delivery Manual. Unfortunately, while this approach has been endorsed, it has not yet come to fruition in most facilities due to resource challenges. In COP 2016, PEPFAR Zimbabwe will implement direct-

¹⁸ HTC will be offered as part of an integrated combination HIV prevention package and clients seeking HTC services will also be screened for TB, and receive family planning counseling and services as required (using leveraged resources from DfID)

¹⁹ According to the UNAIDS “hotspot” analysis, HIV prevalence in migrant agricultural workers, mining areas, and growth points were all above 24 percent.

service delivery community-based adherence and retention models using lay cadres, expert patients, and leveraging the presence of existing community cadres such as village health workers (VHWs) and community case care workers (CCCWs). These community-based interventions will decongest facilities through reduced appointment frequency for stable ART patients, and will be focused in Harare, Aggressive and the DREAMS districts. New Start facilities will employ a Test, Start, Stabilize and Transfer model with an emphasis on finding men and eventually transferring their care to public sector facilities. Adolescents will benefit from the Community Adolescent Treatment Support (CATS) model as implemented through the “Zvandiri” program implemented by Africaid. This model employs adolescents with HIV to provide home-based support to their peers and care givers. PEPFAR implementing partners carrying out community-based adherence support will also assist facilities with defaulter tracing, and improve the M&E associated with community-care referrals. Learning models for community care and support will also include Community ART Refill Groups (CARGs), and community ART initiation as Treat All is gradually incorporated into the national guidelines.

Resources will be allocated to train peer educators and community health care workers to organize and lead peer support group meetings (which provide psychosocial support, early child stimulation, and to deal with disclosure, stigma, adherence issues etc.) increase demand for HIV services and facilitate referrals to care and treatment, hygiene and nutritional support. Community cadres will also employ index HTS strategies to identify the HIV status of other members of households. At the facility, PEPFAR will provide support for clinical mentoring on provision of cotrimoxazole, STI screening, nutritional counseling, and infant feeding counseling. Mentoring support will include on site sensitization training to ensure equitable access to services for all clients, irrespective of sexual orientation.

With the move towards Treat All, PEPFAR partners will continue to provide support for facilities to review all patient entries particularly in pre-ART registers. Where patients outcomes are unknown or where patients are stated as ineligible for ART, facility and community based staff will initiate tracing to ensure they are brought back to care. Community leadership structures, schools, churches and mass media organizations (print/broadcasting) may be called upon to support this activity.

In an effort to improve adherence and retention among adolescents in Zimbabwe, the PEPFAR team will receive an additional \$2.4 million to implement their “game-changer:” Community Adherence Treatment Supporter (CATS) - a differentiated care model for adolescents. The Zvandiri program, currently implemented by Africaid, provides community-based care and support services for HIV-positive children and adolescents and their families through community support groups, Zvandiri centers, and community outreach teams. As part of the Zvandiri program, the Community Adherence Treatment Supporters (CATS) aims to enhance testing, initiation, retention, and adherence in children, adolescents, and young adults. Through the CATS model, HIV-positive children and young people develop the knowledge, skills, and confidence to cope with their HIV status, have improved quality of life, and remain linked with health care systems.

In Zimbabwe, CATS will be implemented in all 36 districts with a focus on 15-24 year olds. This adolescent package of services include psycho-social support, life & coping effectiveness skills enhancement, adherence support with home and facility visits and mobile technology follow-up, and community ARV refill groups (CARGS). The program will work with 407 facilities across all 36

districts to improve adolescent care and treatment services. Specific expected outcomes include: 125,286 PLHIV provided with care services at community level; 87,700 retained in care; 54,657 adolescents aged 15-24 received package of services; and 43,726 adolescents aged 15-24 stable on treatment in CARGS.

4.7 TB/HIV

In accordance with WHO 2013 guidelines, Zimbabwe has adopted a Treat All (Test and Start) approach to PLHIV co-infected with TB. As part of PEPFAR Zimbabwe's core package of services (detailed in Appendix A), continuous sensitization around the guidelines will be provided at all "scale-up" sites to ensure: 1) all TB patients are tested for HIV and immediately prepared for/initiated on ART if positive and 2) HIV positive patients are screened for TB at every contact with health staff. This sensitization process will also focus on improving communication and coordination between TB and OI/ART departments, to facilitate better monitoring and evaluation. For COP 2016, PEPFAR Zimbabwe aims to maintain a linkage rate >80% among newly diagnosed co-infected patients at scale-up facilities. DSD support for facility-based HTS activities will also include an emphasis on improving identification and linkage to ART of co-infected patients.

Through the New Start network focusing on KPs in the 36 scale-up districts, TB screening will be undertaken for all newly identified HIV positive clients using a standardized checklist. HIV positive clients with presumptive TB will be tested for TB using smear microscopy and GenXpert services available through 4 of the 16 New Start sites. The other 12 New Start sites that do not have microscopy and GenXpert services will either refer to another New Start site or MOHCC facility that offers the services. Clients with diagnosed HIV/TB co-infection through the New Start network will be linked and tracked into treatment services.

TB infection control (TBIC) is recognized as an important systems-level activity to reduce nosocomial infections for PLHIV, and to reduce TB infection among health care workers. In COP 2016, TBIC activities will focus on developing and implementing TB screening for health care workers in the scale-up SNU. This activity will also be paired with HIV screening, given the HIV co-infection rate of 69% among TB patients in Zimbabwe. Ongoing site-level support will include improving ventilation, hygiene, isolation of suspected and confirmed cases, and decongestion to reduce TB transmission at health care facilities.

4.8 Adult Treatment

As previously mentioned, the MOHCC is on course to officially launch Treat All. The Guidelines adaptation process, including development of a scale up plan, is currently underway with completion and roll out scheduled before the end of FY 2016. PEPFAR Zimbabwe is playing a key technical leadership role in this process and will continue to provide site readiness support to ensure supported sites are prepared to fully implement the Guidelines as of COP 2016. Treat All is underway in four DREAMS districts as a pilot.

A main challenge for the national ART program was the realization that enrollment numbers had reduced from about 12,000 to 4,000 per month during the latter part of FY 2015. Multiple reasons for this decline have been offered, including a lack of resources needed to actively find those

individuals who are still well and less likely to come to health facilities, particularly adolescents and men. Furthermore, gaps in human resources have impeded strategies such as PITC among patients presenting to facilities, and index testing in the community. The geographic shift was implemented at the beginning of FY 2015, and in the first quarter enrollment rates rose to 8,000 per month. Careful monitoring of MOHCC data will continue, and adjustments to strategy will be made to keep enrollment on track to meet the 90-90-90 targets.

In COP 2016, PEPFAR Zimbabwe will continue to prioritize activities in 36 districts with a focus on sites that have at least 260 ART patients. All sites with less than 260 ART clients and those outside the 36 Scale-Up districts will shift from receiving a “sustained package of services” to central support, which will include ARV distribution and laboratory specimen transport. Support for program implementation (HTS, Care/Treatment, QI) will be reduced over the course of FY 2017 Q1, with partner resources shifted to sites in the Scale-Up districts. In the Scale-Up districts PEPFAR will provide support for facility and community-based HTS activities as well as enrollment into care/ART initiation through DSD activities, particularly in all Aggressive, Harare and DREAMS districts, as detailed below.

New approaches in COP 2016 include:

- Deployment of nurse ART initiation teams to each support approximately 5 facilities in maintaining timely ART initiation necessary as a direct consequence of the massive PITC effort;
- Supporting community expert patients/peer navigators to link HIV positive clients (from communities and within health facilities) to treatment services;
- Supporting high volume health facilities to decongest (through multi-month scripting (Zimbabwe is still officially on single-month prescribing although many facilities have begun to dispense three months of drugs), fast track dispensing, developing community based drug pick-ups), to allow staff more focus on ART initiations and management of new/complex patients;
- Support facilities to improve stock/inventory management of ARVs; and
- Defaulter tracing for ART and pre-ART (until Treat All is implemented).

Defaulter tracing and improved coordination between facility and community-based staff will be very important for retention in care: in COP2016, PEPFAR Zimbabwe is proposing to maintain a loss-to-follow-up rate of 7.5%.

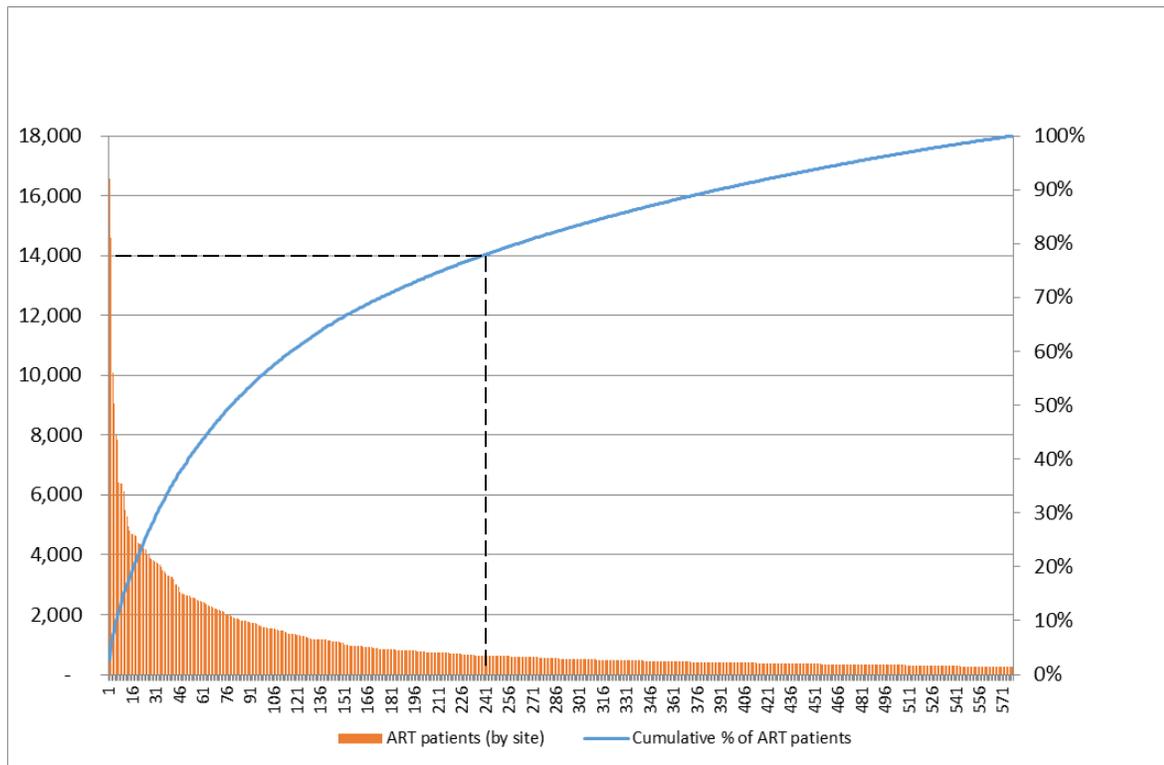
Through expanded support of the national SW program (Sisters with a Voice) PEPFAR will emphasize the identification of new targets and strengthen the clinical cascade among Sex Workers (primary) and men who have sex with men (secondary) in 5 urban locations with high numbers of SWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. This new strategy will employ proven approaches for reaching, testing and immediate initiation of ART for HIV+ SWs and MSM. All HIV+ will be enrolled at New Start KP treatment sites that offer a one-stop shop for health care (HTS, STI, FP, cervical cancer, post GBV care, ART, TB, lab) and provided with viral load monitoring at 6 and 12 months. To address sustainability issues, PEPFAR will provide training and mentoring to selected public health facilities to provide KP friendly services. Once viral suppression has been demonstrated, patients will be transferred to public sector for ongoing ART provision at KP friendly sites.

The current MOHCC net new enrolment rate Global Fund target for 2016 and 2017 is 8,689 patients per month. With the recently approved Global Fund costed extension for calendar year 2017, scale-up of ART will be maintained. Identified cost savings from the current Global Fund grant will be reinvested in ARVs; an ARV funding gap is not expected for 2016 or 2017.

SIMS findings in FY 2016 have shown consistent challenges (yellow or red scores) in certain areas: community referral tracking and defaulter tracking; index testing; ART monitoring (either CD4 or VL); and systematic PITC for children, particularly in malnutrition and inpatient wards. It is for this reason that COP 2016 resources will be focused on addressing these challenges, through a combination of HRH support and documentation tools for defaulter tracking, community referrals, and index testing; HRH support for PITC among children in particular; and laboratory support to improve access to viral load.

The Gender Analysis documented several factors that could impact ART enrollment, adherence and retention. These include lower utilization of HIV services among men, high prevalence of GBV, numerous cultural (and religious) practices and norms that can fuel HIV transmission and/or treatment avoidance, and persistent stigma towards KPs in the healthcare setting. Findings will be used to design new, as well as fine tune existing, program activities including male and adolescent friendly services such as Treat All, mobile/workplace/community ART; flexible clinic hours; GBV screening, counselling and referrals in ART services; availability of male lay/peer cadres for adherence counselling; psychosocial support for groups that may have particular challenges with lifelong ART (children & adolescents, GBV survivors, individuals from conservative religious groups); and rights based training that promotes accepting and positive attitudes towards adolescents, SWs, and MSM. Additionally, the use of male champions to raise awareness on negative gender norms, cultural and religious practices that affect health seeking behavior of men will be implemented.

Figure 4.8.1 September 2015 ART Cumulative Patients and Number on ART in PEPFAR 36 Scale-up Districts²⁰



4.9 Pediatric Treatment

In 2015, the MOHCC developed the Accelerated Action Plan for Pediatric and Adolescent ART in Zimbabwe in anticipation of receipt of ACT Initiative funds through the Children’s Investment Fund Foundation (CIFF). The plan aims to scale up identification of HIV-exposed and infected infants, children and adolescents, using a combination of facility and community based approaches. In recent months, CIFF funds have been provided to the Global Fund for first line pediatric anti-retroviral medicines and as a result, no major challenges have occurred in the supply chain for these commodities. Implementing the ACT work plan and increasing the numbers of children on ART however, has been a challenge in the absence of additional funds. The MOHCC recently conducted individual district specific bottle neck analyses and subsequently developed district specific plans and strategies for reaching HIV infected children. Implementing partners (including PEPFAR partners) will work with individual districts to implement the plans and strategies that fall within the scope of their work plans. The main bottle necks include consistently low early infant diagnosis (EID) coverage with high sample rejection rates, long turn-around times to get EID results, inefficient targeting of children for HIV testing, weak links between OVC programming and clinical services and the relatively centralized ART initiation services for children particularly in urban/higher level facilities. Broader challenges

²⁰ Figure 4.8.1 represents 577 integrated treatment sites PEPFAR supported in COP 2015 which represents 619,503 ART patients.

include the continued use of paper based systems, weak client referral/tracking systems and to some extent the issue of user fees.

To support the MOHCC's national plan, in COP 2016 PEPFAR Zimbabwe aims:

Specifically, PEPFAR Zimbabwe will

- Strengthen and standardize HIV testing in EPI clinics using the child health card
- Support the implementation of evidence-based screening tools for HIV testing in OPDs where sick children are seen
- Continue on site training/mentorship of staff on EID sample collection
- Support transport systems for EID samples and results
- Enhance linkages between OVC programs and health services through strengthened collaboration among community- and facility-based cadres for health and social services.
- Strengthen the implementation of nurse-led pediatric ART initiation particularly in urban/higher level facilities
- Support the MOHCC to implement new pediatric formulations e.g. LPV/r pellets
- Support the scale up of viral load monitoring for children on ART.
- Standardize the use of differentiated models of care to include children and adolescents who are stable on ART

With Global Fund support, the MOHCC continues to scale up the use of electronic patient monitoring systems (ePMS) at facilities. In addition, electronic patient tracking modules have been added to the ePMS and are currently being tested in selected facilities. PEPFAR will support the roll out of these systems through health worker sensitization and soft-ware upgrades.

4.10 OVC

In COP 2016, the OVC program will be operational in 16 Districts - of which 7 are Scale-up Saturation, 8 are Scale-Up Aggressive and 1 is centrally supported. The OVC program will continue to support the graduation and transition of children and families in the remaining centrally supported district until September 2017, at which time the OVC program will withdraw from the district completely. The OVC program will continue to streamline its program content and coverage in order to reach the right children, at the right places at the right time, with the right package of services. The OVC program is operating in 5 of the 6 DREAMS SNU's: Mazowe, Makoni, Mutare, Chipinge and Gweru.

The program will accelerate efforts to identify OVC and caregivers through strengthened coordination between health facilities and community structures. The social welfare case management system, which has now been scheduled for adoption within the MOHCC, will continue, ensuring children/families are assessed for holistic health and social needs, seamlessly linked to the appropriate services, and followed until the case closure. Children and families who are found to be HIV positive or affected by HIV will receive a package of support services including adherence support, education support, economic strengthening, and psychosocial support. Health facilities will also refer children at-risk of sub-optimal health outcomes (poor/low adherence, uninitiated CLHIV, defaulting, malnourished, etc.) to case care workers for community-level assessment and support.

The program will focus on ensuring that the children already enrolled know their HIV status and are linked to appropriate services. Accordingly, there will be close coordination between OVC partners and those implementing facility- and community-based HTS and care/treatment activities. The Special Initiative has been working with community based structures to stimulate demand for pediatric HIV services; support mothers/caregivers and HIV-exposed children 0 – 24mos in order to assure early diagnosis, adherence and retention on treatment; and provide holistic parenting support to optimize HIV-exposed children’s developmental outcomes.

Anecdotal evidence shows that these efforts have been very successful and the program will document the evidence and scale up the successful strategies to all Districts. There is an ongoing randomized control trial to determine the effects of a comprehensive wrap around support package on treatment, adherence and retention in pediatric HIV care. All the four OVC partners are part of the Special Initiative.

The program is currently working with the MOHCC, as well as, the Ministry of Labour and Social Welfare to make the National Case Management System (operational in all districts of Zimbabwe) HIV Sensitive. These efforts will ensure that all community case workers (CCWs) and other community based para-professionals, not just those supported by PEPFAR, are trained in HIV issues with the aim of generating demand for HIV services as well as offering adherence support to those on ART.

Specialized packages of services will be provided to HIV+ OVC and their families, as well as, to other OVC facing other acute challenges, such as GBV. The OVC program is encouraging application of evidence based models for AGYW HIV prevention beyond the DREAMS SNUs. Approximately 5% of children will age out from the OVC program this year.

Implementing partners are using case management to assess child/family needs and resources, develop case plans with concrete family goals, connect families with appropriate services and identify critical actions to be taken by families to improve child wellbeing and protection, monitor implementation of case plans progress towards family goals, and close cases once families have achieved a level of self-sufficiency and are ready to graduate from direct project support. This case management system is based on Zimbabwe’s National Case Management System framework for Child Protection. The system ensures that children who are exposed to HIV/AIDS, violence, abuse and exploitation can access all of the social welfare, justice and specialist healthcare services that they need within a properly coordinated statutory mechanism. Case management has been rolled out in all districts. Each of the partners has signed a MOU with the Ministry of Labour and Social Welfare’s department of Protection Services and Child Welfare, which oversees the roll-out and implementation of case management in the country.

PEPFAR Zimbabwe is acknowledged for its contributions to a strong and coherence social welfare system. The National Case Management System has been foundational to operationalizing the national protocol on the multi-sectoral management of sexual abuse and violence. We plan further investments to consolidate on the successes realized so far, capacitating various community structures and cadres (such as child protection committees, school development committees, child care workers, village health care workers, and health facilities) in GBV response as well as promoting more effective cross referrals. The program will continue to support the implementation of the national case management in the 16 operational districts in partnership with the Government of Zimbabwe.

OVC Interventions	Core	Near-Core
Case Management	<ul style="list-style-type: none"> Beneficiary identification Develop case management plans 	<ul style="list-style-type: none"> National case management scale-up Promote cross-referrals
Health	<ul style="list-style-type: none"> Mobilize communities for accelerated HTS and pediatric ART Adherence assessment, counseling SRH services for adolescents School/community gardens Referrals for nutrition and food security 	<ul style="list-style-type: none"> Training of community based child protection structures Training social and para-social workers
Protection <i>Safe</i>	<ul style="list-style-type: none"> Psychosocial support Succession planning and re-integration Parenting Clubs GBV response Child protection responses and referral 	<ul style="list-style-type: none"> Community places of safety
Economic Strengthening <i>Stable</i>	<ul style="list-style-type: none"> Household economic strengthening (ISALS) Emergency fund for short term support Link to social protection mechanisms 	<ul style="list-style-type: none"> Value chain assessments Market linkages
Education <i>Schooled</i>	<ul style="list-style-type: none"> Access to education Early childhood development linkages with PMTCT and pediatric ART 	<ul style="list-style-type: none"> Child friendly schools Training of school and ECD development committees

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Maintenance package of services in other locations and populations

Sites within the 24 centrally supported districts and sites with fewer than 260 patients in the 36 scale-up districts will receive distribution of ARV and lab commodities as an extension of the national system (central support). These activities are supported by PEPFAR at the national level and all ARVs are channeled through the national system. On a case-by-case basis, PEPFAR may respond to specific requests by the MOHCC for extra support in centrally supported districts and in low-volume sites. In a change from COP 2015, additional PEPFAR support to 54 high-volume sites (those with >680 ART patients) within previously classified sustained districts will not continue in COP 2016. Only support to national level activities and ARV and other commodity distribution will continue in those sites.

OVC investments will continue the transition to scale-up districts by 2018 as agreed in COP 2015. This will not be accomplished by discontinuing any of the OVC currently receiving care, but rather through natural attrition as a result of ageing out and/or “graduating” as a result of economic empowerment activities and other targeted services. Details of the OVC program and transitions can be found in the OVC Transition Plan.

5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Centrally Supported Districts²¹

Maintenance Volume by Group	Expected Result APR16	Expected Result APR17	Percent increase (or decrease)
HIV testing in PMTCT sites PMTCT_STAT	64,114	N/A	
HTC (only maintenance ART sites in FY 16)	N/A	N/A	
Current on ART (Tx_CURR)	86,563	N/A	
OVC (OVC_SERV)	8,626	5,500	36%

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

With the exception of high-volume sites within centrally supported districts and the ongoing OVC transition, all geographic transitions have successfully taken place. COP 2016 will see additional reductions to some centrally supported activities such as funding for DHIS, TBIC, some condom programming and training activities. The PEPFAR team will communicate these changes to the MOHCC and the Global Fund to ensure that key activities can be taken over as necessary. The PEPFAR team will also work closely with the Global Fund CCM to ensure that priority activities will be included in the one-year concept note extension. Two key commodities--ARVs and condoms--will continue to be provided nationwide, and support will continue for related quantification, forecasting, purchase, and delivery. ARV provision will remain essentially unchanged, as will quantification, forecasting and distribution of lab reagents, and lab transport and non-SLMTA lab monitoring.

²¹ With the exception of OVC, all programs in centrally supported districts will shift to central support in COP16

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for achieving Key Programmatic Gaps

The top two key programmatic gaps in the clinical cascade that must be addressed in order to achieve 90-90-90 and sustained epidemic control in Zimbabwe include: 1) increasing HIV testing coverage and yield and subsequently successfully linking identified HIV positive individuals to care and treatment and 2) improving viral load monitoring coverage rates from the current six percent.

In order to increase HIV testing coverage and yield and successfully link those HIV positive individuals into care and treatment the following systems barriers will need to be addressed:

- The limitations with HR capacity at facility level to fully optimize PITC
- Community testing strategy needs to be optimally targeted to identify those not readily identified in the health system, and to increase yield
- HTC policies and strategies are not currently aligned with 90-90-90 and new WHO guidelines
- Supply chain system challenges and funding gaps result in intermittent stock outs of testing commodities and reagents
- Nascent/outdated referral and linkage systems –both within facilities and between community and facility testing platforms

In order to improve viral load monitoring coverage rates the following systems barriers will need to be addressed:

- Inadequate supply of VL testing machines and reagents to scale up according to national VL strategy
- Human resources capacity to implement and manage viral load testing and all access points

Table 6.1.1 Key Programmatic Gap #1: Need for improved HTC alignment and yield

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Supply chain system challenges and funding gaps result in intermittent stock outs of testing commodities and reagents	1. Stock-outs of tracer commodities (RTKs, specific ARVs, etc.), under 5% 2. Selection of all commodities optimized to reduce or eliminate wastage 3. Fully coordinated procurement and supply management system with Global Fund measured by functioning centralized logistical system.	Support to Zimbabwe national pharmaceutical systems continues, including forecasting, quantification, and supply planning.	HTXS	\$650,000	PSM	8. Commodity Security and Supply Chain6.14
		Re-institute regular (bimonthly) bilateral PSM coordination meeting between USG/PEPFAR and UNDP/Global Fund				
		Continue support for Directorate of Laboratory Services (DLS) logistics unit seconded staff (3 positions)	HLAB	\$135,200	PSM	8. Commodity Security and Supply Chain6.14
TOTAL				\$785,200		

6.2 Critical Systems Investments for Achieving Priority Policies

The Government of Zimbabwe is committed to adopting the new WHO 2015 guidelines and rolling out Treat All in the right geographical areas as quickly as possible. The Ministry of Health and Child Care has already begun the adaptation process. In order to fully roll out and scale up these new guidelines the following systems barriers will need to be addressed:

- Implementation of Treat All following national policy revision
- Facility capacity (HRH, infrastructure, and record-keeping) challenges to increased ART scale-up
- Systems for retention and defaulter tracing are weak--both in facilities & communities
- Insufficient funding for ARVs

The PEPFAR Zimbabwe team, alongside the MOHCC, has already identified some new and efficient service delivery models to unburden health facilities yet ensure continuous provision of ARVs to all patients. In COP 2016, the USG will continue to support the roll out of differentiated care models that will provide tailored services based on the different patient stability profiles. In order to implement these models and optimize services the following systems barriers will need to be addressed:

- Supply chain challenges related to extended prescription periods
- Clinical systems are inadequate to permit the necessary follow-up.
- Inadequate access to viral load impedes proper risk stratification of ART patients
- Task-shifting and service delivery paradigms have not fully shifted

Table 6.2.1 Treat All (Test and Start)

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Facility capacity (HRH, infrastructure, and record keeping) challenges to increased ART scale-up	<ol style="list-style-type: none"> All stable patients (approximately 30% of patients on ART) shifted to differentiated care models to decongest facilities Comprehensive ePMS, to facilitate patient care & tracking, rolled out nationwide Improved quality and utilization of data for patient management and programming <ul style="list-style-type: none"> - accurate monthly program reports, accounting for patient transfers - and reliably estimated retention, loss-to follow-up and deaths among ART patients 	M&E support at the national level to improve data quality and utilization (secondees)	HTXS, HVSI	[REDACTED]	TBD	13. Epidemiological and Health Data 3.87
Systems for retention and defaulter tracing are weak--both in facilities & communities	<ol style="list-style-type: none"> National guidelines for improved facility and community linkages, adherence in place Increased coverage of effective community linkage, adherence and retention models (all facilities nationwide utilize standardized 	Continued support for clinical secondees at MOHCC AIDS and TB Program	HBHC, PDTX, PDCS, HTXS	\$400,000	OPHID	7. Human Resources for Health 8.42

	tracking tools, allowing for accurate estimates of linkage rates)					
TOTAL				\$650,000		

Table 6.2.2 New and efficient service delivery models

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Clinical systems are inadequate to permit the necessary follow-up.	<p>1. Improved clinical patient management and all facilities staffed by personnel comfortable with adult and pediatric HIV management, and adhering to national guidelines.</p> <p>2. Facilities use real-time data to identify efficiencies and improve quality of care</p> <p>3. Facilities employ efficient patient management systems and data-first HR, allowing for decision support and rapid identification of potential treatment failures.</p>	<p>Roll-out of mother-baby tracking tool, with additional modules to work as a data-first EHR, and HIS support (DHIS 2)</p> <p>Development of this tool centrally will then permit risk stratification of patients at facility-level, and differentiation of service delivery.</p>	HTXS, PDTX, HVSI	[REDACTED]	TBD	13. Epidemiological and Health Data3.87
TOTAL				\$858,289		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
HRH - Systems/Institutional Investments							
Quality Improvement	National QI Support (HRSA)	First, Second and Third 90	Standardized QI process and methodology implemented throughout the country in accordance with National QI strategy (MOHCC secondees)	300,000	HTXS, PDTX, HVTB	HealthQual	9. Quality Management 8.67
HR Information System	Human Resource Information System; Decentralize to Districts	First, Second and Third 90	a. Complete transition of system to the MOHCC and Regulatory Authorities b. Robust interoperable system in place c. Trained system administrators to maintain the system (7 from councils, 12 from MOHCC, 6 from central hospitals) d. Guidelines to roll out the system to all the other 55 districts will be in place	200,000	OHSS	DCM HITRAC	7.6 HR Data Collection and Use: 1.17
Communications and Public Affairs	Communications activities and coordination with local Civil Society organizations	All three 90s	Broad knowledge of PEPFAR and its programs and strong coordination with local CSOs.	[REDACTED]	HBHC, HVOP, HVSI, OHSS	TBD	3. Policies and Governance 7.16

7.0 Staffing Plan

The PEPFAR team conducted an interagency staffing analysis of current and vacant staffing positions to ensure an adequate mix of technical, management and administrative staff to support 90-90-90 goals. Existing PEPFAR staff are aligned with core and near-core activities described in Appendix A. Significant technical staffing gaps exist for CDC (seven key vacancies) while USAID has filled all but one vacancy. Of the seven previously vacant positions for CDC, three have been repurposed from administrative to technical positions to technical. Three Public Health Specialist vacancies filled and awaiting security clearance, expected by early summer. The remaining positions will focus specifically on Pediatric Treatment, VMMC, M&E and TB/STI/HIV.

SIMS requirements and overall Management and Operations (M&O) needs were reviewed during budgetary discussions. Technical and non-technical staff are conducting SIMS visits on a monthly basis. PEPFAR staff will spend a total of 187 business days per quarter (USAID 148, CDC 38, State 1) in COP 2016.

[REDACTED]

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<ul style="list-style-type: none"> • 1st 90: intensified PITC; community-based HTC focused on high risk populations; strengthened linkages into HIV prevention, care and treatment • 1st 90: WHO-prescribed minimum package of VMMC services to 15-29 yr olds; community-based demand creation & PreP. • 2nd 90: Accelerated Scale up ART including Treat All and Viral Load roll-out • 2nd 90: Pediatric and PMTCT service delivery; intensified TB/HIV case finding and management; community outreach, defaulter tracing, adherence and retention; • 2nd 90: Conduct clinical mentoring, supportive supervision • 2nd/3rd 90: Community Adherence Refill Groups and Community Adolescent Treatment Support Groups • Cross-Cutting: Lab specimen transport; forecasting and distribution of HIV commodities. 	Pediatric Attachments	<ul style="list-style-type: none"> • HIV testing and counseling & Outreach in Sustained Districts • Direct service delivery of early infant male circumcision • Food packages • Directly supporting IGAs with funds and other inputs • Providing micro-credit • CD4
Sub-national level	<ul style="list-style-type: none"> • 1st 90: Distribution of female condoms, RTKs, demand creation for VMMC & commodity distribution 	<ul style="list-style-type: none"> • Promote cross referrals between schools and clinics • Training of community- 	<ul style="list-style-type: none"> • Strengthening birth registration programs • Distribution of Male Condoms

	<ul style="list-style-type: none"> • 2nd 90: TB infection control activities; strengthen district supportive supervision and mentorship; forecasting and distribution of HIV commodities. • 2nd/3rd 90: Lab EQA and mentoring of lab staff for diagnostics. • Cross-Cutting: capacity building for district-level M&E teams to improve data quality • Cross-Cutting: Identification, assessment and case management of OVCs; GBV, nutrition, and child protection referrals; linkage to PMTCT and pediatric ART services and adherence counseling; household economic strengthening; succession planning and social protection 	<ul style="list-style-type: none"> • based child protection structures • Set up community places of safety • Value chain assessments and market linkages • 	
National level	<ul style="list-style-type: none"> • 2nd/3rd 90: Coordination of national HIV activities; supply chain management, forecasting and procurement. • Cross-Cutting: Support for implementation of ePMS, integration of data collection systems; epidemiological surveys (e.g. PMTCT impact evaluation, HIVDR) & DHIS2. 	<ul style="list-style-type: none"> • Work with government and civil society to reduce discrimination • Support for scale up of national case management system • Support training of social and para-social workers 	<ul style="list-style-type: none"> • Support to the National Blood Safety and Transfusion Department • HIV Integrated Trainings • Rebranding of male and female condoms • MOHCC development in leadership, organizational and financial management. • Development and dissemination of national guidelines • HRH Logistic Management System

Table A.2 90-90-90 Core, Near-core, and Non-core Activities for COP 16

<u>HTC</u>	<u>Core Activities</u>	<u>Near-core Activities</u>	<u>Non-core Activities</u>
	<ul style="list-style-type: none"> • PITC (TA) & PITC (HRH) at public health facilities-multiple entry points and in-patient services • Provide community based integrated HTC services to ‘at-risk’ and vulnerable populations e.g. mining areas, trucking routes, sex workers, AGYW • HTC services at both static sites and during outreach activities as part of a package for VMMC to boys and men • Strengthen index patient partner and family testing for adults and peds • TB Screening integration within HTC activities • Strengthen linkages from testing into care, treatment and other prevention services through SMS, peer support counseling and existing community-based structures • Distribution of HIV rapid test kits (RTKs) & HIV Self-Testing Pilot • Carry out demand creation to increase uptake of HTC in prioritized districts and within at-risk, vulnerable and high priority groups e.g. key populations • Address barriers men and women may face accessing HTC services by improving HTC availability (e.g. outreach services, mobile testing sites, workplace) • Testing of at-risk OVCs 	<ul style="list-style-type: none"> • Rapid test quality improvement initiative • Training HTC service providers in how to counsel and appropriately refer women and men who report experiencing GBV 	<ul style="list-style-type: none"> • Procurement of HTKs except to cover emergency gaps • Blanket (Non-Targeted) Testing and Counseling • PITC in Sustained districts
<u>Care and Treatment</u>	<u>Core Activities</u> <ul style="list-style-type: none"> • Treat All • Training, mentoring and supportive supervision to strengthen clinical management of ART and PMTCT (including the incorporation of viral load testing and interpretation) to improve performance in the following areas: <ul style="list-style-type: none"> ○ Support to develop SNU-level IPC committees; ○ Increased screening, intensive case-finding for TB/HIV patients ○ Community Adherence Refill Groups ○ Prevention counseling for PLHIV, OI screening and STI management • Intensified efforts to increase pediatric enrolment: <ul style="list-style-type: none"> ○ Training on EID sample management, results communication, and integration into EPI ○ Intensified PITC in pediatric wards, nutrition centers, and index tracing • HRH support for defaulter tracing and facility/community linkages and referrals • Lab EQA for diagnostics and mentoring of lab scientists (RTKs, , VL, EID, 	<u>Near-core Activities</u> <ul style="list-style-type: none"> • Ongoing supportive supervision and mentorship on ad hoc/PRN basis • Strengthen community systems to provide psychosocial and other support to clients. • HIV Integrated Trainings • Pediatric Attachments 	<u>Non-core Activities</u> <ul style="list-style-type: none"> • <i>None</i>

- etc.)
- Viral Load scale-up transmission/interpretation)
- HIV QI activities and HMIS support (at high-volume sites only)

Prevention	Core Activities	Near-core Activities	Non-core Activities
Condoms	<ul style="list-style-type: none"> • Female condom distribution to social franchising network • As part of an integrated package for HIV prevention, provide vulnerable populations e.g. AGYW, Sex workers, discordant couples, with information about consistent condom use 	<ul style="list-style-type: none"> • Capacity building of Natpharm/ZNFPC to forecast and distribute condoms 	<ul style="list-style-type: none"> • Rebranding of male and female condoms, distribution of male condoms • Procurement of condoms
DREAMS	<ul style="list-style-type: none"> • Interventions designed to prevent GBV and provide linkages to services for post-violence care such as psychosocial and legal services through community-based platforms and PEP • Interventions to empower young women and adolescent girls and engage men and boys to promote positive norms. • PrEP for vulnerable women engaged in Transactional Sex and/or identify as SWs • Cash Transfers, educational subsidies, economic strengthening 	<ul style="list-style-type: none"> • Work with government and civil society to reduce stigma and discrimination 	
VMMC	<ul style="list-style-type: none"> • Provide WHO-prescribed minimum package of VMMC services to 15-29 yr olds • Strengthen demand creation including interpersonal counseling and community mobilization focused on increasing demand among 15-29 yr olds 		
Other Prevention	<ul style="list-style-type: none"> • Community mobilization, health communication to increase demand for and uptake of VMMC, HTC, HIV care and treatment, TB services • Targeted risk assessment and provision of sexual risk reduction strategies and skills • Treatment as prevention 	<ul style="list-style-type: none"> • Research 	
HSS	<ul style="list-style-type: none"> • Laboratory specimen transport and Viral Load • SCM forecasting, procurement and distribution of HIV commodities including VMMC • QA/QI: clinical/systems mentoring, national quarterly supportive supervision • eLMIS, and TA • Secondments 	<ul style="list-style-type: none"> • Work with district and ward level established structures e.g. DACs to strengthen coordination of HIV prevention services • Refine established mapping techniques to identify at risk and vulnerable groups and based on results continue to align HIV prevention activities to these groups 	<ul style="list-style-type: none"> • Direct service delivery of early infant male circumcision
		<ul style="list-style-type: none"> • DHIS2 	

OVC	Core Activities	Near-core Activities	Non-Core Activities
Case Management Identification of OVC	<ul style="list-style-type: none"> • Identification of OVC • Vulnerability Assessments • Development of Case management plans 	<ul style="list-style-type: none"> • National scale up of case management system 	
Healthy (Access to Health and HIV Services)	<ul style="list-style-type: none"> • Support community structures to engage and mobilize communities for Accelerated Pediatric ART • Promoting adherence, assessment, counseling • SRH services for adolescents 	<ul style="list-style-type: none"> • Promoting cross referrals e.g. between clinics and schools 	
Safe (Protection)	<ul style="list-style-type: none"> • Community Gardens • Referrals for nutrition and food security 	<ul style="list-style-type: none"> • Training of community based child protection structures • Training social and para-social workers • Setting-up of Community Places of safety 	
Stable,(Economic Strengthening)	<ul style="list-style-type: none"> • Psychosocial Support/ GBV Response • Succession planning and re-integration • Parenting Clubs • Child Protection Responses & Referrals 	<ul style="list-style-type: none"> • value chain assessments • Market linkages 	
Education	<ul style="list-style-type: none"> • Education Subsidies • Supporting early childhood development, linkages with PMTCT and pediatric ART • Household economic strengthening (ISALS) • Emergency fund for short term economic support • Early childhood development, linkages with PMTCT and pediatric ART 	<ul style="list-style-type: none"> • Creating child friendly schools • Training of school and ECD development committees 	

Table A.3 Transition Plans for Non-core Activities 2016

<u>Transitioning Activities</u>	<u>Type of Transition</u>	<u>Funding in COP15</u>	<u>Estimated Funding in COP16</u>	<u># of IMs</u>	<u>Transition End Date</u>	<u>Notes</u>
Rebranding of male and female condoms	Phase out	\$0	\$0		2015	
Distribution of Male Condoms	Leverage USAID non-PEPFAR	\$500,000	\$0	1	2016	
TB Surveillance	Phase out	\$100,000	\$0	1	2015	Negotiating with Global Fund
Providing food packages	Strengthen nutrition gardens in selected ECDs and schools	\$0	\$0		2015	
Strengthening birth registration systems	Transition to UNICEF	\$0	\$0		2015	
Leadership, Management, Training for District Health Teams	Phase out	\$0	\$0		2015	Support will be provided by the Donor Health Transition Fund
Providing Micro-credit	Link mature ISAL groups to MFIs (Steward Bank and Micro plan)	\$0	\$0		2015	Trainings will be transitioned to the GF and World Bank
HIV Integrated Trainings	Phase-Out	\$4,481,284	\$0	3	2016	Existing trainings planned for COP 2015 will be re-purposed to focus on Treat All.
Pre-service training	Phase-out	\$0	\$0		2015	

APPENDIX B

B.1 Planned Spending in 2016

Applied Pipeline	New Funding	Total Spend
\$0	\$101,000,000	\$101,00,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$1,309,769
HVAB	Abstinence/Be Faithful Prevention	\$766
HVOP	Other Sexual Prevention	\$896,458
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$13,143,370
HVCT	Counseling and Testing	\$9,894,719
HBHC	Adult Care and Support	\$3,985,245
PDCS	Pediatric Care and Support	\$716,547
HKID	Orphans and Vulnerable Children	\$ 7,589,019
HTXS	Adult Treatment	\$26,718,602
HTXD	ARV Drugs	\$ 21,971,822
PDTX	Pediatric Treatment	\$3,295,443
HVTB	TB/HIV Care	\$1,638,563
HLAB	Lab	\$220,081
HVSI	Strategic Information	\$1,419,003

OHSS	Health Systems Strengthening	\$815,782
HVMS	Management and Operations	\$7,384,801
<hr/>		
TOTAL		\$101,000,000

B.2 Resource Projections

PEPFAR Zimbabwe unit expenditures (UE) from the most recent available data (2015) and the PEPFAR Budget Allocation Calculator (PBAC) were used to calculate the required resources to support targets for HTC, adult and pediatric care and treatment, PMTCT, VMMC, key populations and OVC. With support from the EA Advisor assigned to Zimbabwe, adjustments to UEs were made to account for anticipated changes to the program in the coming implementation year, including geographic and site focus, outlier remediation, and changes to models/packages of service delivery and support. For differentiated models of care not implemented in COP 2015, unit expenditures from MOHCC pilot programs and costs from other donors were analyzed against existing partner costs to establish estimated expenditures for COP 2016. Efficiency gains were taken into consideration especially for VMMC to explore opportunities to reduce overall costs including increased procurements for PrePex and utilization of reusable kits. PEPFAR Zimbabwe utilized a per person costing approach in lieu of a per facility budgeting approach to align costs with service delivery model, geography and target population.

B. 2.1 Differentiated Models of Care Target Based Budgeting Example

PEPFAR Zimbabwe is introducing two new differentiated models of care in support of Treat All and to identify hard to reach populations in need of ART. As indicated in the below figure, a surge of HRH capacity will be utilized to reach the first and second through community mobilization and outreach, back to care initiatives and defaulter tracing from the facility to the community.

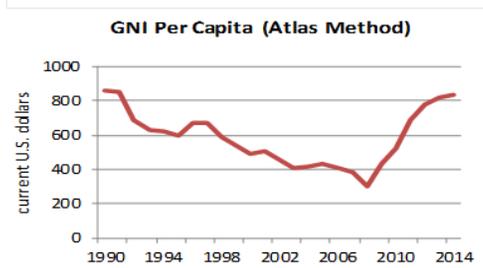
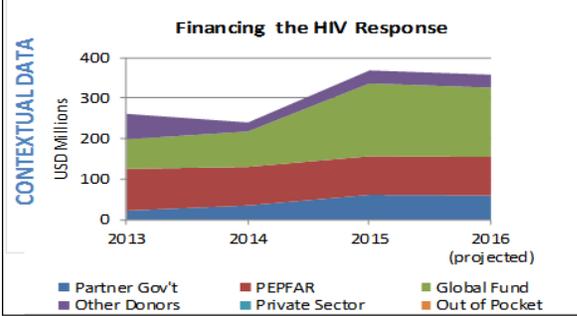


APPENDIX C

Sustainability Analysis for Epidemic Control: Zimbabwe

Epidemic Type: Generalized
 Income Level: Low-income
 PEPFAR Categorization: Long-term Strategy
 PEPFAR COP 16 Planning Level: 95,000,000

	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.33			
2. Policies and Governance	7.16			
3. Civil Society Engagement	6.17			
4. Private Sector Engagement	2.71			
5. Public Access to Information	8.00			
National Health System and Service Delivery				
6. Service Delivery	7.22			
7. Human Resources for Health	8.42			
8. Commodity Security and Supply Chain	6.14			
9. Quality Management	8.67			
10. Laboratory	4.72			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	3.06			
12. Technical and Allocative Efficiencies	6.70			
Strategic Information				
13. Epidemiological and Health Data	3.87			
14. Financial/Expenditure Data	7.08			
15. Performance Data	7.34			



CONTEXTUAL DATA

National Clinical Cascade

Epidemiological Data

Population and Fertility

Population Pyramid (2015)